

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12040

CERTIFICATE OF DEATH

12013

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. STREET ADDRESS 3808 Davis Place, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Liza Middle Inez Last Abernathy		4. DATE OF DEATH Month November Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1957
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Billy V. Abernathy		14. MOTHER'S MAIDEN NAME Inez Helen Clary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fulmonary Congestion 754.4 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 mos. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 19 57 , to November 19, 19 57 , that I last saw the deceased alive on November 19, 19 57 , and that death occurred at 8:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carlos R. Lombardo, M.D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 11/19/57			
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 11-19-57	
22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Gaffney, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 11-20-57		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE, ALABAMA		UNITED STATES OF AMERICA	
RACE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		RELIGION		CAUSE OF DEATH	
WHITE		LABORER		HIGH SCHOOL		MARRIED		ARMY		METHODIST		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
APRIL 4 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		UNITED STATES OF AMERICA		APRIL 8 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	

BUREAU V. 2

NOV 21 1967

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12014

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY in 1b 13 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sandy Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hosp.		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Carrie Bell Addison		4. DATE OF DEATH Month Nov. Day 30 Year 1957	9. AGE (In years last birthday) 45 yrs.
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Malvin Powell		14. MOTHER'S MAIDEN NAME Josephine Hackett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Record
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 954x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Being prepared for teeth extraction. Died under Sodium Pentothal Anes.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 11/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/3/57	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REG. BY REGISTRAR DEC 2 1957 24b. REGISTRAR'S SIGNATURE Trude Lowery	

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DEC 2 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

120157

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

12042

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Einey	c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. County General		d. STREET ADDRESS Brooke Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clarence Thompson Anderson		4. DATE OF DEATH Nov. 23, 1957	Day Year 19
5. SEX Male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/28
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Landscape	11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Anderson	
14. MOTHER'S MAIDEN NAME Roberta Christian		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Montg. Co. Police, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 981X DUE TO Hemorrhage from laceration of liver and puncture of abdominal aorta & rt. Iliac artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shot gun wound in rt. abdomen (c) Shot gun wound in rt. abdomen			INTERVAL BETWEEN ONSET AND DEATH 25 min. 25 min. 25 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Reported shot by brother with 12 ga. shot gun			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported shot by brother with 12 ga. shot gun	
20c. TIME OF INJURY Month, Day, Year 3 Hour 20 p.m. 11/23/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Sandy Spring, Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-28-57	22c. NAME OF CEMETERY OR CREMATORY Crook County	22d. LOCATION (City, town, or county) (State) Danville Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines		24a. REC'D BY REGISTRAR NOV 27 1957	
ADDRESS 10-901-3088		24b. REGISTRAR'S SIGNATURE Gertrude Larkins	

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RECEIVED

NOV 27 1957

BUREAU A. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12003

CERTIFICATE OF DEATH

12016

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington San & Hosp</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Yakoma Park Md</u>				d. STREET ADDRESS <u>211 Virginia Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>Donna</u> Middle <u>Lee</u> Last <u>Atkey</u>		4. DATE OF DEATH		Month <u>11</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-56</u>		9. AGE (In years last birthday) <u>18 mo</u> year	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Paul W. Atkey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status epilepticus</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-6</u> , 19 <u>57</u> , to <u>11-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-6</u> , 19 <u>57</u> , and that death occurred at <u>11-5 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert D Glick</u>				ADDRESS (Street, city or town, state) <u>8301 Pines Br. Rd Silver Spring, Md</u>		DATE SIGNED <u>11/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Herbert D. Glick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24. RECEIVED BY REGISTRAR <u>NOV 12 1957</u> REGISTRAR'S SIGNATURE <u>J. Watson</u>	

RECEIVED

NOV 12 1957

BUREAU V. 5

12500

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. CAUSE OF DEATH: [illegible]

8. PLACE OF DEATH: [illegible]

9. DATE OF DEATH: [illegible]

10. SIGNATURE OF DECEASED: [illegible]

11. SIGNATURE OF WITNESS: [illegible]

12. SIGNATURE OF PHYSICIAN: [illegible]

13. SIGNATURE OF CORONER: [illegible]

14. SIGNATURE OF JUDGE: [illegible]

15. SIGNATURE OF CLERK: [illegible]

16. SIGNATURE OF [illegible]: [illegible]

17. SIGNATURE OF [illegible]: [illegible]

18. SIGNATURE OF [illegible]: [illegible]

19. SIGNATURE OF [illegible]: [illegible]

20. SIGNATURE OF [illegible]: [illegible]

21. SIGNATURE OF [illegible]: [illegible]

22. SIGNATURE OF [illegible]: [illegible]

23. SIGNATURE OF [illegible]: [illegible]

24. SIGNATURE OF [illegible]: [illegible]

25. SIGNATURE OF [illegible]: [illegible]

26. SIGNATURE OF [illegible]: [illegible]

27. SIGNATURE OF [illegible]: [illegible]

28. SIGNATURE OF [illegible]: [illegible]

29. SIGNATURE OF [illegible]: [illegible]

30. SIGNATURE OF [illegible]: [illegible]

31. SIGNATURE OF [illegible]: [illegible]

32. SIGNATURE OF [illegible]: [illegible]

33. SIGNATURE OF [illegible]: [illegible]

34. SIGNATURE OF [illegible]: [illegible]

35. SIGNATURE OF [illegible]: [illegible]

36. SIGNATURE OF [illegible]: [illegible]

37. SIGNATURE OF [illegible]: [illegible]

38. SIGNATURE OF [illegible]: [illegible]

39. SIGNATURE OF [illegible]: [illegible]

40. SIGNATURE OF [illegible]: [illegible]

41. SIGNATURE OF [illegible]: [illegible]

42. SIGNATURE OF [illegible]: [illegible]

43. SIGNATURE OF [illegible]: [illegible]

44. SIGNATURE OF [illegible]: [illegible]

45. SIGNATURE OF [illegible]: [illegible]

46. SIGNATURE OF [illegible]: [illegible]

47. SIGNATURE OF [illegible]: [illegible]

48. SIGNATURE OF [illegible]: [illegible]

49. SIGNATURE OF [illegible]: [illegible]

50. SIGNATURE OF [illegible]: [illegible]

51. SIGNATURE OF [illegible]: [illegible]

52. SIGNATURE OF [illegible]: [illegible]

53. SIGNATURE OF [illegible]: [illegible]

54. SIGNATURE OF [illegible]: [illegible]

55. SIGNATURE OF [illegible]: [illegible]

56. SIGNATURE OF [illegible]: [illegible]

57. SIGNATURE OF [illegible]: [illegible]

58. SIGNATURE OF [illegible]: [illegible]

59. SIGNATURE OF [illegible]: [illegible]

60. SIGNATURE OF [illegible]: [illegible]

61. SIGNATURE OF [illegible]: [illegible]

62. SIGNATURE OF [illegible]: [illegible]

63. SIGNATURE OF [illegible]: [illegible]

64. SIGNATURE OF [illegible]: [illegible]

65. SIGNATURE OF [illegible]: [illegible]

66. SIGNATURE OF [illegible]: [illegible]

67. SIGNATURE OF [illegible]: [illegible]

68. SIGNATURE OF [illegible]: [illegible]

69. SIGNATURE OF [illegible]: [illegible]

70. SIGNATURE OF [illegible]: [illegible]

71. SIGNATURE OF [illegible]: [illegible]

72. SIGNATURE OF [illegible]: [illegible]

73. SIGNATURE OF [illegible]: [illegible]

74. SIGNATURE OF [illegible]: [illegible]

75. SIGNATURE OF [illegible]: [illegible]

76. SIGNATURE OF [illegible]: [illegible]

77. SIGNATURE OF [illegible]: [illegible]

78. SIGNATURE OF [illegible]: [illegible]

79. SIGNATURE OF [illegible]: [illegible]

80. SIGNATURE OF [illegible]: [illegible]

81. SIGNATURE OF [illegible]: [illegible]

82. SIGNATURE OF [illegible]: [illegible]

83. SIGNATURE OF [illegible]: [illegible]

84. SIGNATURE OF [illegible]: [illegible]

85. SIGNATURE OF [illegible]: [illegible]

86. SIGNATURE OF [illegible]: [illegible]

87. SIGNATURE OF [illegible]: [illegible]

88. SIGNATURE OF [illegible]: [illegible]

89. SIGNATURE OF [illegible]: [illegible]

90. SIGNATURE OF [illegible]: [illegible]

91. SIGNATURE OF [illegible]: [illegible]

92. SIGNATURE OF [illegible]: [illegible]

93. SIGNATURE OF [illegible]: [illegible]

94. SIGNATURE OF [illegible]: [illegible]

95. SIGNATURE OF [illegible]: [illegible]

96. SIGNATURE OF [illegible]: [illegible]

97. SIGNATURE OF [illegible]: [illegible]

98. SIGNATURE OF [illegible]: [illegible]

99. SIGNATURE OF [illegible]: [illegible]

100. SIGNATURE OF [illegible]: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12043

CERTIFICATE OF DEATH

12017

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1726 South Nelson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Karl Middle Bernard Last Baessell		4. DATE OF DEATH Month November Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 May 1901
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Baessell		14. MOTHER'S MAIDEN NAME Mina Maher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 579-05-0782	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of lungs 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Epidermal Carcinoma of floor of mouth DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 mos 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 1957 , to November 3, 1957 , that I last saw the deceased alive on November 3, 1957 , and that death occurred at 9:55p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Couch		DATE SIGNED 11/4/57	
PHYSICIAN'S NAME (Type) ROBERT B. COUCH, M. D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Fairfax County Va.	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Loeppel, Arlington, Va		24a. REC'D BY REGISTRAR DATE 11-6-57	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 110 Carroll Street, S.E.	
3. NAME OF DECEASED (Type or print) First William Middle Bernard Last BERG		4. DATE OF DEATH Month November Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 August 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles BERG		14. MOTHER'S MAIDEN NAME Amanda (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) William B. BERG, Jr. (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X MITRAL Stenosis - Post-operative DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Emphysema and Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Sept. , 19 57 , to 28 November , 19 57 , that I last saw the deceased alive on 28 November , 19 57 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Douglas Robert Koth		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-29-57	
PHYSICIAN'S NAME (Type) Douglas Robert KOTH, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-3-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE James Ryan, Inc.		24a. REC'D BY REGISTRAR DATE 11-29-57	
ADDRESS James Ryan, 317 Penn Ave., S.E. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Harry B. Masella	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES (JIM) ...		MALE		35		...	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
...		
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		...	
...		
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		
...		

RECEIVED
BUREAU V. 2
 DEC 4 1957

12045 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rudolph Middle None Last Berger				4. DATE OF DEATH Month November Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 June 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager				10b. KIND OF BUSINESS OR INDUSTRY Film Industry		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Berger				14. MOTHER'S MAIDEN NAME Justine (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) WWI				16. SOCIAL SECURITY NO. 578-03-7838		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic carcinoma of the breast INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington				20g. (County) Virginia		20h. (State) Virginia	
21. I certify that I attended the deceased from November 2, 1957 , to November 6, 1957 , that I last saw the deceased alive on November 6, 1957 , and that death occurred at 3:55 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 11/7/57			
ACTUAL SIGNATURE Mortimer B. Lipsett M.D.							
PHYSICIAN'S NAME (Type) Mortimer B. Lipsett, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler Son				ADDRESS 4756 K Ave N.W.		24a. REC'D BY REGISTRAR NOV 12 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G222 11-18-57 et.

12046

CERTIFICATE OF DEATH

12020

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 113 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3906 C Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Henry Betts		4. DATE OF DEATH Month November Day 11, Year 19 57					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1912	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lot Boy		10b. KIND OF BUSINESS OR INDUSTRY Used Car		11. BIRTHPLACE (State or foreign country) North Carolina			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME (Unknown) Betts					
14. MOTHER'S MAIDEN NAME Henrietta		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					
16. SOCIAL SECURITY NO. 224-01-0156		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) years INTERVAL BETWEEN ONSET AND DEATH minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Washington		20g. (County) D. C.		20h. (State) D. C.			
21. I certify that I attended the deceased from July 21, 19 57, to November 11, 1957, that I last saw the deceased alive on 11/10, 19 57, and that death occurred at 5:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) NIH Bethesda Md DATE SIGNED 11-11-57 ACTUAL SIGNATURE James C. [Signature] M.D. NIH Bethesda Md PHYSICIAN'S NAME (Type) James C. [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			
22d. LOCATION (City, town, or county) Washington		22e. (State) D. C.		22f. (Country) D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.		23a. ADDRESS 901 3rd St. S.E.		23b. REC'D BY REGISTRAR NOV 14 1957			
23c. REGISTRAR'S SIGNATURE Beattie Thompson		23d. REGISTRAR'S SIGNATURE Beattie Thompson					

CERTIFICATE OF DEATH

Form 1-14-11

PLACE IN DEATH		PLACE IN DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY	
17. SIGNATURE OF DEPUTY REGISTRAR		18. SIGNATURE OF DEPUTY CORONER	
19. SIGNATURE OF DEPUTY JURY		20. SIGNATURE OF DEPUTY WITNESSES	
21. SIGNATURE OF DEPUTY PHYSICIAN		22. SIGNATURE OF DEPUTY MANNER OF DEATH	
23. SIGNATURE OF DEPUTY PLACE OF BIRTH		24. SIGNATURE OF DEPUTY PLACE OF DEATH	
25. SIGNATURE OF DEPUTY DATE OF BIRTH		26. SIGNATURE OF DEPUTY DATE OF DEATH	
27. SIGNATURE OF DEPUTY AGE		28. SIGNATURE OF DEPUTY SEX	
29. SIGNATURE OF DEPUTY RACE		30. SIGNATURE OF DEPUTY OCCUPATION	
31. SIGNATURE OF DEPUTY MANNER OF DEATH		32. SIGNATURE OF DEPUTY CAUSE OF DEATH	
33. SIGNATURE OF DEPUTY SIGNATURE OF PHYSICIAN		34. SIGNATURE OF DEPUTY SIGNATURE OF REGISTRAR	
35. SIGNATURE OF DEPUTY SIGNATURE OF CORONER		36. SIGNATURE OF DEPUTY SIGNATURE OF JURY	
37. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY REGISTRAR		38. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CORONER	
39. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY JURY		40. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY WITNESSES	
41. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PHYSICIAN		42. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH	
43. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF BIRTH		44. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF DEATH	
45. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF BIRTH		46. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF DEATH	
47. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY AGE		48. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SEX	
49. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY RACE		50. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY OCCUPATION	
51. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH		52. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CAUSE OF DEATH	
53. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF PHYSICIAN		54. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF REGISTRAR	
55. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF CORONER		56. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF JURY	
57. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY REGISTRAR		58. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CORONER	
59. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY JURY		60. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY WITNESSES	
61. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PHYSICIAN		62. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH	
63. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF BIRTH		64. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF DEATH	
65. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF BIRTH		66. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF DEATH	
67. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY AGE		68. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SEX	
69. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY RACE		70. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY OCCUPATION	
71. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH		72. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CAUSE OF DEATH	
73. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF PHYSICIAN		74. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF REGISTRAR	
75. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF CORONER		76. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF JURY	
77. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY REGISTRAR		78. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CORONER	
79. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY JURY		80. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY WITNESSES	
81. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PHYSICIAN		82. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH	
83. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF BIRTH		84. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY PLACE OF DEATH	
85. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF BIRTH		86. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY DATE OF DEATH	
87. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY AGE		88. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SEX	
89. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY RACE		90. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY OCCUPATION	
91. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY MANNER OF DEATH		92. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CAUSE OF DEATH	
93. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF PHYSICIAN		94. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF REGISTRAR	
95. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF CORONER		96. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF JURY	
97. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY REGISTRAR		98. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY CORONER	
99. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY JURY		100. SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY SIGNATURE OF DEPUTY WITNESSES	

BUREAU V. 2

NOV 14 1957

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

NOV 29 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12048

CERTIFICATE OF DEATH

Reg. Dist. No.

12022 16

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #1, Box 25			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Troy		Middle None		Last Blankenship	
4. DATE OF DEATH		Month November		Day 1		Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 September 1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Blankenship				14. MOTHER'S MAIDEN NAME Harriet Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-18-2084		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral Stenosis, postoperative mitral commissurotomy							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 13 , 19 57 , to November 1 , 19 57 , that I last saw the deceased alive on November 1 , 19 57 , and that death occurred at 11:35 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/1/57 ACTUAL SIGNATURE Carlos R. Lombardo M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11/2/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Welsh, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. ADDRESS Wash. D.C.				24a. REC'D BY REGISTRAR NOV 5 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF BIRTH	
JAMES H. HARRIS		1912	
PLACE OF BIRTH		MARYLAND	
DATE OF DEATH		1957	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
OCCUPATION		LABORER	
EDUCATION		HIGH SCHOOL	
RELIGION		METHODIST	
MARRIAGE		MARRIED	
SPOUSE		JANE HARRIS	
CHILDREN		3	
FAMILY HISTORY		NONE	
PREVIOUS ILLNESS		NONE	
TREATMENT		NONE	
BURIAL		BALTIMORE	
CEREMONY		NONE	
FUNERAL HOME		NONE	
CITY		BALTIMORE	
STATE		MARYLAND	
COUNTY		BALTIMORE	
WITNESSES		NONE	
SIGNATURE OF DECEASED		NONE	
SIGNATURE OF NEXT OF KIN		NONE	
SIGNATURE OF PHYSICIAN		NONE	
SIGNATURE OF CLERK		NONE	
SIGNATURE OF REGISTRAR		NONE	

RECEIVED
NOV 5 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Dr. Frank J. Broschart, MD, Medical Examiner for Montgomery County
Notified.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12023

12049

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 hr.45 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carlisle		75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 32 East Ridge	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Henry Last BOSTOCK, Jr.		4. DATE OF DEATH Month November Day 28 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 May 1927
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Massa chusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George H. BOSTOCK, Sr.		14. MOTHER'S MAIDEN NAME Helen Malloney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) Yes (If yes, give war or dates of service) 1945 to 1949		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Father, George H. Bostock, Sr. (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dissecting Aneurysm of Sinus of Valsalva DUE TO Hypertension & Coarctation of Aorta (c) 17 hrs. 12 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-28- , 19 57 to 11-28- , 19 57 , that I last saw the deceased alive on 11-28- , 19 57 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
1 ACTUAL SIGNATURE Douglas Robert Koth M.D.		U.S. Naval Hospital, Bethesda, Md. 11-29-57	
PHYSICIAN'S NAME (Type) Douglas Robert Koth, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-57	
22c. NAME OF CEMETERY OR CREMATORY St. Patricks		22d. LOCATION (City, town, or county) (State) Carlisle, Pennsylvania	
23. FEDERAL DIRECTOR'S SIGNATURE Lutz Hoffman ADDRESS 219 N. Hanover St. Carlisle, Pa.		24a. REC'D BY REGISTRAR DATE 11-29-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parselley			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH 1887		6. DATE OF DEATH 1957	
7. PLACE OF DEATH U.S. Naval Hospital, Bethesda, Md.		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. HARRIS		11. SIGNATURE OF REGISTRAR J. H. HARRIS		12. SIGNATURE OF WITNESSES J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF NEXT OF KIN J. H. HARRIS		15. SIGNATURE OF CLERK J. H. HARRIS	
16. SIGNATURE OF CHURCH CLERK J. H. HARRIS		17. SIGNATURE OF MINISTER J. H. HARRIS		18. SIGNATURE OF RABBI J. H. HARRIS	
19. SIGNATURE OF JUDGE J. H. HARRIS		20. SIGNATURE OF SHERIFF J. H. HARRIS		21. SIGNATURE OF CORONER J. H. HARRIS	
22. SIGNATURE OF DISTRICT ATTORNEY J. H. HARRIS		23. SIGNATURE OF COUNTY CLERK J. H. HARRIS		24. SIGNATURE OF CITY CLERK J. H. HARRIS	
25. SIGNATURE OF STATE CLERK J. H. HARRIS		26. SIGNATURE OF FEDERAL CLERK J. H. HARRIS		27. SIGNATURE OF POSTAL CLERK J. H. HARRIS	
28. SIGNATURE OF MARINE CLERK J. H. HARRIS		29. SIGNATURE OF NAVY CLERK J. H. HARRIS		30. SIGNATURE OF AIR FORCE CLERK J. H. HARRIS	
31. SIGNATURE OF ARMY CLERK J. H. HARRIS		32. SIGNATURE OF COAST GUARD CLERK J. H. HARRIS		33. SIGNATURE OF MARSHAL CLERK J. H. HARRIS	
34. SIGNATURE OF INSPECTOR CLERK J. H. HARRIS		35. SIGNATURE OF CHIEF CLERK J. H. HARRIS		36. SIGNATURE OF ASSISTANT CLERK J. H. HARRIS	
37. SIGNATURE OF DEPUTY CLERK J. H. HARRIS		38. SIGNATURE OF CLERK IN CHARGE J. H. HARRIS		39. SIGNATURE OF CLERK AT LARGE J. H. HARRIS	
40. SIGNATURE OF CLERK OF THE HOUSE J. H. HARRIS		41. SIGNATURE OF CLERK OF THE SENATE J. H. HARRIS		42. SIGNATURE OF CLERK OF THE SUPREME COURT J. H. HARRIS	
43. SIGNATURE OF CLERK OF THE DISTRICT COURT J. H. HARRIS		44. SIGNATURE OF CLERK OF THE CIRCUIT COURT J. H. HARRIS		45. SIGNATURE OF CLERK OF THE COUNTY COURT J. H. HARRIS	
46. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		47. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		48. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
49. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		50. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		51. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
52. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		53. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		54. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
55. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		56. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		57. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
58. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		59. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		60. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
61. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		62. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		63. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
64. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		65. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		66. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
67. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		68. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		69. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
70. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		71. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		72. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
73. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		74. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		75. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
76. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		77. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		78. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
79. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		80. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		81. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
82. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		83. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		84. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
85. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		86. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		87. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
88. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		89. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		90. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
91. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		92. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		93. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
94. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		95. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		96. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
97. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		98. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		99. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	
100. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT J. H. HARRIS		101. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT J. H. HARRIS		102. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT J. H. HARRIS	

RECEIVED
U.S. NAVAL HOSPITAL, BETHESDA, MD.
DEC 2 1957

RECEIVED
BUREAU V. S.
DEC 2 1957

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12050

CERTIFICATE OF DEATH

12024

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Zion		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Zion	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookville, R.F.D.		d. STREET ADDRESS Brookville, R.F.D.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lydia Ann Bowen		4. DATE OF DEATH Month Day Year Nov. 28 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1866
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mid-wife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Bowen		14. MOTHER'S MAIDEN NAME Ann Askins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		17. INFORMANT Address Merlin S. Williams, Takoma Pk., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Sclerosis DUE TO (c) Hypertensive Cardiorenal Disease		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus Respiratory Infection Nov. 11, 1957		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 16, 1946 , to November 28, 1957 , that I last saw the deceased alive on Nov. 27, 1957 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Norbeck RFD 1 Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-2-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion	22d. LOCATION (City, town, or county) (State) Mt. Zion, Mont. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Sacher, Laytonville, Md.		24a. REC'D BY REGISTRAR DATE 11-30-57	
		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Richard Bowen		Male		38		Nov. 22, 1957	
Place of Birth		Race		Occupation		Cause of Death	
Brockville, R.F.D.		Colored		None		Heart Disease	
Name of Informant		Relationship		Signature of Informant		Signature of Registrar	
Ann Askins		Wife		[Signature]		[Signature]	
Name of Physician		Address of Physician		Name of Hospital		Name of Burial Place	
None		None		None		None	

BUREAU V. S.

DEC 9 1957

RECEIVED

11-20-57

CERTIFICATE OF DEATH

Reg. Dist. No.

120256

12051

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>11005 Haven Park Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eliza</u> Last <u>Bowers</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/89</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Thomas Hines</u>		14. MOTHER'S MAIDEN NAME <u>Mary Holt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Harold Williams</u>		Address <u>1406 L. Street Long Island, NY.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute peritonitis</u> DUE TO (c) <u>Diverticulitis of the colon (probable)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 6, 1957</u> , to <u>November 9, 1957</u> , that I last saw the deceased alive on <u>November 8, 1957</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9301 Coleville Rd., Silver Spring, Md.</u> DATE SIGNED <u>Nov. 9, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Coleville Rd., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 14 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12052

CERTIFICATE OF DEATH

Reg. Dist. No. 12026

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md</u>				c. LENGTH OF STAY IN 1b <u>28 Days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3				d. STREET ADDRESS <u>1734 "P" Street N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Bowie</u> Last <u>Bowie</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 13, 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Charles Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Miss Hattie Bowie-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, essential</u> DUE TO (c) <u>Arteriosclerosis, advanced</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>5 yrs +</u> <u>5 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:16</u> , 1957, to <u>11:51</u> , 1957, that I last saw the deceased alive on <u>11:41</u> , 1957, and that death occurred at <u>3:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11:55</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> 3921 Ingomar St., N. W.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

FILE NO. 11

DATE OF DEATH 11/11/57		PLACE OF DEATH Home	
DECEASED JAMES H. HARRIS		AGE 68	
SEX Male		RACE White	
BIRTH DATE 11/11/18		BIRTH PLACE Maryland	
MARRIAGE Married		SPOUSE Maryland	
OCCUPATION Retired		EDUCATION High School	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESS Maryland	
DATE OF SIGNATURE 11/11/57		PLACE OF SIGNATURE Home	
SIGNATURE OF PHYSICIAN James H. Harris		DATE OF SIGNATURE 11/11/57	
PLACE OF SIGNATURE Home		SIGNATURE OF DECEASED James H. Harris	
DATE OF SIGNATURE 11/11/57		PLACE OF SIGNATURE Home	

BUREAU V. 1

NOV 8 1957

RECEIVED

Washington

Greenwood

Robert A. Humphrey - Baltimore, Md.

12053

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 105 Quincy St. Ch. Ch		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chevy Chase, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chevy Chase, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Worthington Last Bowling		4. DATE OF DEATH Month 11 Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1868
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 1 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Love		14. MOTHER'S MAIDEN NAME Ann Hall Worthington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John P. Bowling		Address same as 2 d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute (cardiac) congestive failure DUE TO 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardio-vascular generalized arterio DUE TO sclerosis (c) Rheumatic Heart disease INTERVAL BETWEEN ONSET AND DEATH 22 days 10 years 70 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 , 19 38 , to Nov 29 , 19 57 , that I last saw the deceased alive on Nov 2 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 Military rd. etc. DATE SIGNED 11/29/57			
ACTUAL SIGNATURE Gilbert B. Rude		M.D. Gilbert B Rude	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/2/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 12-2-57		24b. REGISTRAR'S SIGNATURE Brasida Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

1957 5 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12028

12054

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5320-41st St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>PAULINE LORETTE BOYCE</u>		4. DATE OF DEATH <u>Nov 1 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31-1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hewitt</u>		14. MOTHER'S MAIDEN NAME <u>Emma Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>William Boyce Jr.</u>		Address <u>5720-20 St. N.E. Apt. 1 - D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Circulatory Failure</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <u>Pulmonary Embolism</u> lying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-29</u> , 19 <u>57</u> , to <u>11-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-31</u> , 19 <u>57</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Russell M. Tilley, Jr. 4701- Mass. Ave. N.W. Wash. D.C.</u>		DATE SIGNED <u>11-1-57</u>	
ACTUAL SIGNATURE <u>Russell M. Tilley, Jr.</u>		M.D. <u>Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Russell M. Tilley, Jr.</u>		M.D. <u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, or other disposition <u>burial</u>		22b. DATE THEREOF <u>11/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash, DC</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jessie Thompson</u>	

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12055

CERTIFICATE OF DEATH

Reg. Dist. No.

120216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3292 Arcadia Pl. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>C</u> Last <u>Brähler</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 5 1890</u> 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engraving</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brähler</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hartig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>463X</u>		17. INFORMANT Address <u>MRS Marie E. Brähler - wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO <u>463X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>THROMBOSIS VEINS OF LEG</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Oct. 30, 1957</u> , to <u>Nov. 11, 1957</u> , that I last saw the deceased alive on <u>Nov. 11, 1957</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Sidney E. Cousins</u> M.D. <u>3921 Ingomar St. N.W. 11/11/57</u>				PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u> <u>read & B</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. - 2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Male White
State Printer Bureau of Printing Washington, D.C.
Jimmie J. White
Otto C. Brothers
2222 Georgia St. N.E.
Washington, D.C.
Mrs. Marie C. Brothers - wife

BUREAU V. S.

NOV 18 1957

RECEIVED

12056

CERTIFICATE OF DEATH

12080

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Falls Church			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 311 Kent Street			
3. NAME OF DECEASED (Type or print) First George Middle (nmn) Last BRENNAN				4. DATE OF DEATH Month November Day 13 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael BRENNAN				14. MOTHER'S MAIDEN NAME Isabel BOWIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I & II		17. INFORMANT 029 24 0465 Son, George L. Brennan (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) unk.						INTERVAL BETWEEN ONSET AND DEATH 22 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 22 Oct. , 19 57 , to 13 Nov. , 19 57 , that I last saw the deceased alive on 13 Nov. , 19 57 , and that death occurred at 8:28 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-14-57							
ACTUAL SIGNATURE T. S. Dunn, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) T. S. DUNN, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. NAME OF FUNERAL HOME Fitzgerald Funeral Home				24a. REC'D BY REGISTRAR DATE 11-14-57		24b. REGISTRAR'S SIGNATURE Mary E. Parselley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 25 years		SEX Male		RACE White		DATE OF BIRTH 15 March 1931		PLACE OF BIRTH U.S.	
RESIDENCE 1111 North Street, Baltimore, Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	
BIRTHPLACE Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	
BIRTHPLACE Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	

BUREAU V. S.

U.S. Naval Hospital, Bethesda, Maryland, NOV 18 1957

RECEIVED

NAME OF DECEASED JAMES H. HARRIS		AGE 25 years		SEX Male		RACE White		DATE OF BIRTH 15 March 1931		PLACE OF BIRTH U.S.	
RESIDENCE 1111 North Street, Baltimore, Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	
BIRTHPLACE Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	
BIRTHPLACE Maryland		DATE OF DEATH 18 Nov 1957		PLACE OF DEATH U.S. Naval Hospital, Bethesda, Maryland		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 11-1-57	

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14,2 Filed 222 11-18-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 278

12031

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>1614-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Restmore Nursing Home</u>				d. STREET ADDRESS <u>5020 Huron Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Selma</u> Middle <u>Goldsborough</u> Last <u>Broadfoot</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Keyser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charlotte Louise Palmer - 5020 Huron St. College Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diverticulitis + Abscess</u> DUE TO (c) <u>Diverticulosis left Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 mo</u> <u>3 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Nov 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>57</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915 19th St. NW</u> DATE SIGNED ACTUAL SIGNATURE <u>William Kurstin</u> M.D. <u>Same</u> PHYSICIAN'S NAME (Type) <u>William Kurstin MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lincoln Rd NE WASH DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Essie Thompson</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12032

12004

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Takoma Park</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Ellen</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/1/75</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.P.</u>		13. FATHER'S NAME <u>John Wesley Pinkard</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Lang</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Washington Sanitarium + Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis Right internal Carotid Artery</u> 36 hrs (c) <u>carcinoma (Basal cell) of Rt Orbit</u> 12 yrs				INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal Skull Fracture</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>10-31-1957</u> to <u>11-1-1957</u> , that I last saw the deceased alive on <u>11-1-1957</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7701 Canall Ave Takoma Park, Md.</u> DATE SIGNED <u>11-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Ph. Geo. Co. Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW. L.C.</u>			
24a. REC'D BY REGISTRAR <u> </u> DATE <u>11/4/57</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

NOV 6 1957

BUREAU V. S.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12033

12058

Item 14 Film G222 11-25-57 et

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>2 yrs</u>		d. STREET ADDRESS <u>13606 Athania st.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13606 Athania st.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leonard Edward Brosh</u>		4. DATE OF DEATH <u>Nov 13 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2, 1914</u>
9. AGE (in years last birthday) <u>43 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Record manager</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brosh</u>		14. MOTHER'S MAIDEN NAME <u>Mae Kroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>U.S. Gov.</u>	
17. INFORMANT <u>Ethel Brosh (wife)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) <u>History of previous attacks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschat</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschat</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>18 Nov 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>KINALDI FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>NOV 18 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 18 1957

RECEIVED

Boyd / 18 Nov 1957
Kinard, Funeral Home

12005

CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		d. STREET ADDRESS <u>2730 Wisconsin Ave., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Elizabeth</u> (Lynch) Middle <u>Cecelia</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/96</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & Retired Clerk-GAO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>(Jeremiah) JERRY Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Donovan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>53</u>	
17. INFORMANT <u>Miss Florence M. Lynch</u>		Address <u>53 Elsway West Medford, Mass.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Congestive Cardiac Failure</u> DUE TO (c) <u>Chr. Rheumatic Art disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>years?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4/57</u> , 1957, to <u>Nov 1</u> , 1957, that I last saw the deceased alive on <u>Oct 31</u> , 1957, and that death occurred at <u>1:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4600 Carroll Ave, Tak. Park, Md.</u> DATE SIGNED <u>11/1/57</u>			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 1957</u>	
ADDRESS <u>Wash. D.C. 14th St., N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dobby</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 5 1957

RECEIVED

12059

CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>999 - Germantown</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		d. STREET ADDRESS <i>1 Rural</i>	
3. NAME OF DECEASED (Type or print) First <i>Levi</i> Middle <i>Brown</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>7-</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1898 March-28-1898</i>
9. AGE (In years last birthday) <i>39 yrs</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>7</i> Days <i>10</i> Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>day laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>land-reaping</i>	
11. BIRTHPLACE (State or foreign country) <i>Germantown, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred Tillman Brown</i>		14. MOTHER'S MAIDEN NAME <i>Clara Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>217-14-7921</i>	
17. INFORMANT <i>Anna Prather, 99-1, Germantown, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute indigestion</i> <i>481X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Influenza</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov-1-</i> , 19 <i>57</i> , to <i>Nov-7-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov-3-</i> , 19 <i>57</i> , and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William E. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7 - Brooke Ave</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>William E. Miller, M.D.</i>		<i>Gaithersburg, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/14/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 18 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mlanda Brooks</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INVESTIGATED STATE DEPARTMENT OF HEALTH - DISTRICT OF COLUMBIA

DATE OF DEATH

11/19/57

11/19/57

11/19/57

11/19/57

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BUREAU V. S.

NOV 19 1957

RECEIVED

APPROVED BY

11/19/57

11/19/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 11 Film G223 12-12-57 et
12006
CERTIFICATE OF DEATH

12036
773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>6104-4th</u> b. COUNTY <u>St. N.W.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>804 Maple Ave. Takoma Park</u>		d. STREET ADDRESS <u>6104-4th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ida</u> Last <u>Burgess</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16-1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Ormer</u>	
14. MOTHER'S MAIDEN NAME <u>Rachael Kloefer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>son</u> Address <u>Herbert L. Burgess 7523 Hampden Lane, Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Nov. 25, 1957</u> , that I last saw the deceased alive on <u>Nov 21, 1957</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. White</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Carroll Ave. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Takoma Park, 12 mo</u>		DATE SIGNED <u>11-25-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

BUREAU V. S.

1957 28 Aug

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G222 11-20-57 et
12060
12037
Certificate of Death

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>824 West Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LULU</u> Middle <u>W.</u> Last <u>BUTTERMORE</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Louis W. White</u>				14. MOTHER'S MAIDEN NAME <u>Kelly May Berry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>Mr. Kay Jean White, 824 West Ave. S.S. Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma Rt Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/20</u> , 19 <u>52</u> , to <u>11/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>57</u> , and that death occurred at <u>10:57 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dean H. Harding</u>				ADDRESS (Street, city or town, state) <u>113 Carroll St NW, Wash DC</u> DATE SIGNED <u>11/13/57</u>			
PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>Nov. 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Scottdale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Scottdale, Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Dr. NW</u>				24a. REC'D BY REGISTRAR <u>D. C. NOW</u> DATE <u>11/13/57</u>			
				24b. REGISTRAR'S SIGNATURE <u>Francis Patter</u>			

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12038

12061

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRETT PARK WASHINGTON</u> 47X-3	
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		d. STREET ADDRESS <u>3701 16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>3701 16th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES B. CHAMBERLIN</u>		4. DATE OF DEATH Month Day Year <u>NOV 21 19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>JAN 8-1875</u>	9. AGE (In years last birthday) <u>82 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PHARMACIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>THOMAS OLIVER CHAMBERLIN</u>		14. MOTHER'S MAIDEN NAME <u>DIMIS I VES.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>SON.</u> Address <u>HERBERT S. CHAMBERLIN - 1554 EASTWEST</u> H&A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary atherosclerosis</u> (b) <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 Days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 18</u> , 19 <u>57</u> , to <u>Nov. 21</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe MD.</u>		ADDRESS (Street, city or town, state) <u>10511 SUMMIT AVE</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE</u>		<u>KENSINGTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Mem. Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey Silver Spring</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 25 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

BUREAU V. S.

NOV 25 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

12007

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				d. STREET ADDRESS <u>7510 Jackson Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Chang</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Chinese</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>35</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>35</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>China</u>							
13. FATHER'S NAME <u>Jacob (NMN) Chang</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe T-Ju Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mother's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>Circumvalate placenta</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 26, 1957</u> , to <u>November 26, 1957</u> , that I last saw the deceased alive on <u>November 26, 1957</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emma Hughes</u>				ADDRESS (Street, city or town, State) <u>7600 Carroll Ave. - Takoma Park, Md.</u>			
DATE SIGNED <u>12/6/57</u>							
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D. 7600 Carroll Ave., Takoma Park 12, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fox</u>				ADDRESS <u>Washington Sanitarium & Hosp.</u>		24a. REC'D BY REGISTRAR <u>J. M. Deak</u>	
DATE <u>12/6/57</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075231XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	

BUREAU V. 3

DEC 9 1957

RECEIVED

1
[Faint vertical text on the right margin]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12040
214

12062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME				d. STREET ADDRESS 6304-7th ST N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IUV First Middle Last G CHASE				4. DATE OF DEATH Month NOV. Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 21, 1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASH. D. C.	
13. FATHER'S NAME FRANK M. GREEN				14. MOTHER'S MAIDEN NAME NANCY J. PRESBREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-32-4906			
17. INFORMANT Mrs. Nancy C. Brown Address 4710 N. H. Ave. Wash. D.C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia & Exhaustion 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Osteomyelitis left hip DUE TO (c) Generalized and Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis with left hemiplegia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/10/57 , 19____, to 11/17/57 , that I last saw the deceased alive on 11/10/57 , 19____, and that death occurred at 12:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Horace H. Custis M.D. 1852 Columbia Rd NW 11/17/57				DATE SIGNED			
PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR WASHINGTON 9, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
CREMATION		NOV. 18, 1957		Kees Crematory		Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee ADDRESS Wash. D. C.				24a. REC'D BY REGISTRAR NOV 19 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Age: <i>57</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Race: <i>White</i></p>	
<p>7. Occupation: <i>Teacher</i></p>		<p>8. Cause of death: <i>Heart Disease</i></p>	
<p>9. Date of death: <i>Nov 15, 1957</i></p>		<p>10. Place of death: <i>Home</i></p>	
<p>11. Signature of physician: <i>[Signature]</i></p>		<p>12. Signature of registrar: <i>[Signature]</i></p>	

BUREAU V. S.

NOV 19 1957

RECEIVED

12063

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cuba b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 214 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Banes, Oriente 90x-3			
d. STREET ADDRESS c/o United Fruit Sugar Company				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Richard Last Chaulk				4. DATE OF DEATH Month November Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1907	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk				10b. KIND OF BUSINESS OR INDUSTRY Fruit Produce		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Adam Chaulk				14. MOTHER'S MAIDEN NAME Rebecca Lethbridge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (malignant) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 HRS. 2 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cryoglobulinemia & Chronic Glomerulonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 19 , 19 57 , to November 19 , 19 57 , that I last saw the deceased alive on November 19 , 19 57 , and that death occurred at 4:22 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/20/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Robert W. Weiger M.D.				PHYSICIAN'S NAME (Type) Robert W. Weiger, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit				22b. DATE THEREOF 11/20/57		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) Miami, Florida				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 11-21-57		24b. REGISTRAR'S SIGNATURE Beattie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 25 1957

BUREAU V. S.

12-7-19

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Abstract

Accounting Clerk

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The Clinical Center, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12064 CERTIFICATE OF DEATH

12042

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>5207 Worthington Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Coyne</u>				14. MOTHER'S MAIDEN NAME <u>Ellen ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Fred L. Knoblock</u> Address <u>same as 2 d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG 11</u> , 19 <u>57</u> , to <u>Nov. 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>57</u> , and that death occurred at <u>3-17 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5206 NORWAY DR. CHEVY CHASE, MD</u> DATE SIGNED <u>11/22/57</u>							
ACTUAL SIGNATURE <u>Henry H. Houdren</u> M.D.							
PHYSICIAN'S NAME (Type) <u>HENRY H. HOUDREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>11/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Payne Co. Oklahoma</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Patter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 26 1957

BUREAU V. S.

2-18

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

12065

CERTIFICATE OF DEATH

12043

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. STREET ADDRESS 2022 Columbia Road N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nell Middle Margaret Last CLARK		4. DATE OF DEATH Month November Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Oct. 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew MC MURDY		14. MOTHER'S MAIDEN NAME Catherine MC NALLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis with occlusion, 420.1 DUE TO Right Coronary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH One Week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 November, 19 57 , to 15 November, 19 57 , that I last saw the deceased alive on 14 November, 19 57 , and that death occurred at 12:03AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert G. Galbraith, Jr.		M.D. U.S. Naval Hospital, Bethesda, Md. 11-15-57	
PHYSICIAN'S NAME (Type) Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 517 11th St., N.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 11-15-57	24b. REGISTRAR'S SIGNATURE Mary E. Connelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NOV 29 1957

RECEIVED

12066

CERTIFICATE OF DEATH

12044

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood, Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood, Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5209 Chamberlin Avenue		d. STREET ADDRESS 5209 Chamberlin Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clair Middle Irvine Last COGHLIN		4. DATE OF DEATH Month November Day 14 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1868
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months 3 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel R. Irvine		14. MOTHER'S MAIDEN NAME Margaret Sinclair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Alice S. C. Merchant-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 792x Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/1/46 , 19 46 , to 11/14/57 , 19 57 , that I last saw the deceased alive on 11/14/57 , 19 57 , and that death occurred at 4:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul D. Cantor		ADDRESS (Street, city or town, state) 4209 Montgomery Lane, Bethesda, Maryland	
PHYSICIAN'S NAME (Type) Paul D. Cantor, M.D.		DATE SIGNED 11/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 11/15/1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE 11-16-57	24b. REGISTRAR'S SIGNATURE Beattie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Kenneth, Dennis		Age 32		Sex Male		Race Caucasian		Date of Birth November 19, 1925		Place of Birth Boston, Massachusetts	
Residence 3200 Chestnut Avenue		Occupation Clerk		Cause of Death None		Manner of Death None		Date of Death November 19, 1957		Place of Death Boston, Massachusetts	
Physician Dr. J. J. [illegible]		Hospital None		Burial Place None		Burial Date None		Burial Place None		Burial Date None	
Signature of Physician [illegible]		Signature of Registrar [illegible]		Signature of Deceased None		Signature of Next of Kin None		Signature of [illegible] None		Signature of [illegible] None	

BUREAU V. S.

NOV 19 1957

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12045

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Jerome</u> Last <u>Coleman</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-57</u>			
9. AGE (in years last birthday) <u>2</u> yrs. <u>19</u> months <u>19</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Lucius Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Christine Poge</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Grandfather</u> Address <u>Walter Poge - Stewart Lane - White Oak Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> <u>2 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>			
				24a. REC'D BY REGISTRAR <u>NOV 22 1957</u>		DATE <u>11-16-57</u>			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 22 1957

RECEIVED

12067

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 18 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 3915 13th Street, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Albert Middle Norman Last CONTEE				4. DATE OF DEATH Month November Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Dec. 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James CONTEE				14. MOTHER'S MAIDEN NAME Rosetta (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Adell M. CONTEE (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of Heart DUE TO (c) unk				INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 28 Oct. , 19 57 , to 15 Nov. , 19 57 , that I last saw the deceased alive on 14 Nov. , 19 57 , and that death occurred at 5:15 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T.S. Dunn, Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-15-57			
PHYSICIAN'S NAME (Type) T.S. DUNN, JR, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis Funeral Home				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE 11-15-57	
				24b. REGISTRAR'S SIGNATURE Mary G. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 613 Stonestreet Ave	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Harry First Cooper Middle Last		4. DATE OF DEATH Nov. 7, 1957 Month Day Year	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/28
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Cooper	
14. MOTHER'S MAIDEN NAME Florence Carroll		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Police Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 982x DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of Superior Vena Cava Vein (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stab wound in chest (no details)		20c. TIME OF INJURY Month, Day, Year Hour 11/7/57 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Rockville		(County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/57	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR NOV 12 1957
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 12 1957

BUREAU V. 2

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
LABORATORY
DIVISION

LABORATORY REPORT

NO. 100-100000

DATE: 11/12/57

TO: [illegible]

FROM: [illegible]

RE: [illegible]

TESTS PERFORMED: [illegible]

RESULTS: [illegible]

COMMENTS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12069

CERTIFICATE OF DEATH

12048, 17

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Randallstown d. STREET ADDRESS 8407 Charlton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stanley Middle Norman Last Corak		4. DATE OF DEATH Month November Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 November 1922	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months 3 Days 4 Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Auto Parts		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Corak		14. MOTHER'S MAIDEN NAME Lillian Meyerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW II Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DILATATION 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY INSUFFICIENCY DUE TO (c) MALIGNANT MELANOMA INTERVAL BETWEEN ONSET AND DEATH 4 days 7. 2 wks. 3 1/2 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10 , 19 57 , to November 7 , 19 57 , that I last saw the deceased alive on November 7 , 19 57 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 11/8/57 The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-57		22c. NAME OF CEMETERY OR CREMATORY Cath. T. Felon	
22d. LOCATION (City, town, or county) (State) Balto Md		23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Mc ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE NOV 12 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson					

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		Male		45		1910		New York	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
MARRIED		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1955		New York		1957		New York		Heart Disease	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR	
Teacher		High School		Catholic		White		White	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE	
1957		10:00 AM		New York		New York		New York	

BUREAU V. S.

NOV 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12070

CERTIFICATE OF DEATH

12049216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Pr. George's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland 16X2-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5665 Bock Terrace, S. E.			
3. NAME OF DECEASED (Type or print) First William Middle Omer Last Cornelius				4. DATE OF DEATH Month November Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 21, 1882 75 yrs.	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Mason Cornelius				14. MOTHER'S MAIDEN NAME Minnie Margaret Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unavailable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONITIS DUE TO (c) ATHEROSCLEROTIC HRT. DISEASE						INTERVAL BETWEEN ONSET AND DEATH SECONDS 1 WEEK SEVERAL YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 5, 1957 , to November 10, 1957 , that I last saw the deceased alive on Nov. 8, 1957 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 120 CENTER DRIVE, BETHESDA, MD DATE SIGNED 11-10-57							
ACTUAL SIGNATURE Allen D. Goodman M.D.							
PHYSICIAN'S NAME (Type) ALLEN D. GOODMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Nov 13-57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery Washington DC		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				24. REC'D BY REGISTRAR NOV 12 1957			
ADDRESS 1661 Hope Rd				24b. REGISTRAR'S SIGNATURE Jessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12050

12071

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 13 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parris Island (Marine Corps Base)		d. STREET ADDRESS Quarters 242 77X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennifer Middle Anne Last DITTMAR		4. DATE OF DEATH Month November Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Nov. 1953
9. AGE (In years last birthday) 4		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Willits DITTMAR		14. MOTHER'S MAIDEN NAME Eunice F. MURRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Robert W. DITTMAR (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.I. Hemorrhage, massive 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 min 14 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Nov. 19 57 to 16 Nov. 19 57 , that I last saw the deceased alive on 16 Nov. 19 57 , and that death occurred at 9:00P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-18-57			
ACTUAL SIGNATURE J.C. Parke Jr		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) J.C. PARKE, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 11-19-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Prince George County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Huntemann Funeral Home 5732 Georgia Ave. N.W.		24a. REC'D BY REGISTRAR 11-18-57 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED JOHN J. HARRIS		DATE OF BIRTH 12-15-1895	
PLACE OF BIRTH NEW YORK, N.Y.		DATE OF DEATH 11-15-1957	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		PLACE OF DEATH HOME	
EDUCATION 8 YEARS		MARITAL STATUS MARRIED	
RELIGION CATHOLIC		PREVIOUS ILLNESS NO	
SPECIAL OCCASION NO		SIGNATURE OF DECEASED JOHN J. HARRIS	
SIGNATURE OF WITNESS JOHN J. HARRIS		SIGNATURE OF PHYSICIAN JOHN J. HARRIS	
SIGNATURE OF CLERK JOHN J. HARRIS		SIGNATURE OF REGISTRAR JOHN J. HARRIS	

Handwritten notes and signatures in the lower section of the form, including a large signature across the middle.

BUREAU V. 3

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12072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G222 11-20-57 et

Reg. Dist. No. 217

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN lb 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.		e. STREET ADDRESS 313 Quaint Acres	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wilcher Loree Donley Middle Last		4. DATE OF DEATH Nov. 12, 1957 Month Day Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Married <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1877
9. AGE (In years 1 day 1 month 1 year) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician (retired)		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Donley		14. MOTHER'S MAIDEN NAME Nancy A. Leroy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 291-10-5737	17. INFORMANT Hosp. Record Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 900.7 DUE TO Fracture of T 8 & fractures of 10,11,12 ribs Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 days (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at nursing home		
20c. TIME OF INJURY 1:55 11/6/57 Month Day Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Sharon Nursing home	20f. (City or town) (County) (State) Sandy Spring Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 11/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 11/16/57	22c. NAME OF CEMETERY OR CREMATORY DAYTON MEM. PARK CEMETERY	22d. LOCATION (City, town, or county) (State) DAYTON, OHIO
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 15 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lawler	

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NOV 15 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashtons Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashtons</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Hill</u> Middle <u>House</u> Last		4. DATE OF DEATH Month <u>11</u> - Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles T. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Edith Hill House</u>		Address <u>Trans. Silver Sp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arterio Sclerosis</u> DUE TO <u>4 yrs</u> (c) <u>Hypertension</u> DUE TO <u>49 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>C</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/6/57</u> , 19 <u>57</u> , to <u>11/25/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/23/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 p.m.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. Bird</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Sandy Spring</u>		M.D. <u>Sandy Spring</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Herb B. Linder</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12009

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>W.</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>				d. STREET ADDRESS <u>1325 Sheridan St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Edwin</u> Last <u>Dudley</u>				4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-95</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard - Telephone Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>C & P. Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>				13. FATHER'S NAME <u>Joseph E. Dudley</u>			
14. MOTHER'S MAIDEN NAME <u>Louva Shepherd</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Chart</u>				17. INFORMANT <u>Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia of right lung</u> DUE TO <u>493x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis, advanced</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Nov 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6234 Ga Ave NW Wash DC</u>							
ACTUAL SIGNATURE <u>D.B. Washington</u> M.D. <u>6234 Ga Ave NW Wash DC</u>							
PHYSICIAN'S NAME (Type) <u>D.B. Washington M.D. 6234 Ga Ave NW Wash DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 47 Manassas Ave</u>				24. REG'D BY REGISTRAR <u>NOV 5 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>John D. Dady</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE	
LABORER		HEART DISEASE		NATURAL		HOME		NOV 10 1957		10 30 AM		11		30	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM		CORONER'S NO.		REGISTRATION NO.		FILING NO.		INDEX NO.	
None		None		None		None		12345		67890		11111		22222	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF FILER		SIGNATURE OF INDEXER		SIGNATURE OF CLERK	

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NOV 5 1957
BUREAU V. 3

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE BUREAU OF HEALTH. IT IS THE POLICY OF THE BUREAU TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC FOR RESEARCH AND STATISTICAL PURPOSES. ANY VIOLATION OF THIS POLICY WILL BE PROSECUTED TO THE FULL EXTENT OF THE LAW.

CERTIFICATE OF DEATH

Reg. Dist. No. 217

12074

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural- Damascus			
d. STREET ADDRESS 1 R.F.D. Monrovia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lydia Lyles Dunnally				4. DATE OF DEATH Month Day Year Nov. 3 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Lyles				14. MOTHER'S MAIDEN NAME Eliza Foreman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Inez McAbee, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Remonhage 422.1 DUE TO Intense subacute cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 years							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1947 , to Nov. 3, 1957 , that I last saw the deceased alive on Nov. 3, 1957 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr		M.D. Damascus, Md.		ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 11/5/57	
PHYSICIAN'S NAME (Type) James P. Kerr		Damascus, Md.		11/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Friendship Meth.		22d. LOCATION (City, town, or county) (State) Nr. Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Moler				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE 11-5-57	
				24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. 2

NOV 18 1957

RECEIVED

12075

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6012 Roseland Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Dunkham</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor - CPA. Federal Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dayton Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Dunkham</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Wife - 6012 Roseland Lane</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old Age - stroke June 1957</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov 15, 1957</u> , to <u>Nov 15, 1957</u> , that I last saw the deceased alive on <u>Nov 15, 1957</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u>		ADDRESS (Street, city or town, state) <u>8601 old Georgetown Rd Bethesda 14 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR _____		24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtrope</u>	
DATE _____		per DK.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Note: Dr Broochast called by phone via Bethesda - Police Station Permission given to sign certificate

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NOV 21 1957

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BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

CERTIFICATE OF DEATH

12056

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS <u>South Lawn Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Campbell</u> Last <u>Dwyer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/2/23</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maddox & Hopkins</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Marion Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-9600</u>	
17. INFORMANT <u>Ruth Dwyer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>26</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/23</u> , 19 <u>57</u> , to <u>11/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>57</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Higom</u>		DATE SIGNED <u>11/27/57</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Higom</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wis. Ave. Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude Lowrey</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

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NOV 29 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12057

12077 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home		d. STREET ADDRESS 6620 River Road 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMELIA Middle S. Last EDWARDS		4. DATE OF DEATH Month 11 Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27-1865
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 1 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry Simons		14. MOTHER'S MAIDEN NAME Jane Blewett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Elizabeth E. Hamer-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS DUE TO (c) ESSENTIAL HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 27 , 1954, to 11-2 , 1957, that I last saw the deceased alive on 11-2 , 1957, and that death occurred at 7:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 NORWAY DR DATE SIGNED ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) HENRY M. LOWDEN CHEVY CHASE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Transit		22b. DATE THEREOF 11/3/57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Knoxville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 11-4-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1957	
AGE		SEX	
68		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
Myocardial Infarction		Coronary Artery Disease	
PRE-EXISTING DISEASES		TREATMENT	
Hypertension		None	
DIAGNOSIS		HISTORICAL DATA	
Myocardial Infarction		Patient had been ill for several days with chest pain and shortness of breath.	
DATE OF REPORT		REPORTED BY	
JAN 11 1957		JAMES H. HARRIS	
SIGNATURE		TITLE	
JAMES H. HARRIS		Physician	

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CERTIFICATE OF DEATH

Reg. Dist. No.

216

12078

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY Cape May			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 d days 3 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Stone Harbor, New Jersey 67X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Janet E. Fable				4. DATE OF DEATH Month Nov. Day 11 Year 19 57			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1886		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Phila Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Abraham Grayson				14. MOTHER'S MAIDEN NAME Annie Richards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Fable Wash. 16, D.C. Mr. Robert Fable (Son) 5118 Duwall Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 10 YRS.						INTERVAL BETWEEN ONSET AND DEATH 55 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 9, 1957 , to Nov. 11, 1957 , that I last saw the deceased alive on Nov. 11, 1957 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo M. Curtis				ADDRESS (Street, city or town, state) 8218 WISCONSIN AVE DATE SIGNED 11/11/57			
PHYSICIAN'S NAME (Type) LEO M. CURTIS, M.D.				BETHESDA, MD.			
22a. BURIAL—CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Delaware Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash. DC		24a. REC'D BY REGISTRAR DATE NOV 13 1957	
				24b. REGISTRAR'S SIGNATURE Hessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. ROY		2. SEX MALE		3. AGE 68		4. DATE OF BIRTH 1887		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION RETIRED		7. MARITAL STATUS MARRIED		8. RACE WHITE		9. RELIGION CATHOLIC		10. EDUCATION HIGH SCHOOL	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME		13. DATE OF DEATH 1957		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF NEAREST RELATIVE [Signature]		20. SIGNATURE OF CLERK [Signature]	

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NOV 13 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12059

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Connecticut b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> 175 First Street Strafford 45X-3	
d. STREET ADDRESS 175 First Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Leland Last FERGUSON		4. DATE OF DEATH Month November Day 13 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1922
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviation Pilot		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jay Leland FERGUSON		14. MOTHER'S MAIDEN NAME Carrie MOODIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal burns, 3rd degree, entire body area 861X DUE TO except soles of feet, upper left chest and Conditions, if any, which gave rise to immediate cause (b) small areas of back (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aircraft Accident, Plane turned over and caught fire while landing			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft Accident, Plane turned over and caught fire while landing	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 p. m. Nov. 12 1957		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Air Base		20f. (City or town) (County) (State) Patuxent River (St. Mary's) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-57	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Bridgeport, Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons Gawler's & Sons, 1756 Penn. Ave., N.W.		24a. REC'D BY REGISTRAR DATE 11-13-57	
24b. REGISTRAR'S SIGNATURE May E. Carrelly			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

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15 1957

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1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Lackawanna			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 55 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1309 Academy Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Gerald Jerome Ferrick				4. DATE OF DEATH Month Day Year November 9, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Joseph Ferrick				14. MOTHER'S MAIDEN NAME Katherine Lawless			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Un available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Epidermoid Carcinoma To Brain + base of Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epidermoid Carcinoma of lip DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Purulent Meningitis, Toxic Hepatitis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 15, 1957 , to November 9, 1957 , that I last saw the deceased alive on November 8, 1957 , and that death occurred at 12:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alvin H. Harris				M.D. N. H. Bethesda, Md.		DATE SIGNED 11-9-57	
PHYSICIAN'S NAME (Type) Alvin H. Harris, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL-Transit 11-12-57		11-12-57		St. Catherine's Cem.		Lackawanna County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE R. G. Humphrey Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 11-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12081

CERTIFICATE OF DEATH

12061

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN PHILLIP FREY</u>				4. DATE OF DEATH Month Day Year <u>NOV 29 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 20 - 1891</u>	
9. AGE (In years last birthday) <u>86 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>JULIA BEAUDRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>SON</u> Address <u>3031 SEDGWICK ST. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive myocardial Failure</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Advanced coronary arteriosclerosis</u> DUE TO <u>10 yrs +</u> (c) <u>Generalized arteriosclerosis</u> <u>10 yrs +</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction in 1948</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1948</u> , 19 <u>57</u> , to <u>NOV 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 28</u> , 19 <u>57</u> , and that death occurred at <u>105 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>3921 Ingomar St N.W. Washington D.C.</u>				DATE SIGNED <u>Nov 29 1957</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>BEC 2</u>		24b. REGISTRAR'S SIGNATURE <u>James Thompson</u>	

RECEIVED

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>2500 Que Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alva</u> Middle <u>Gallagher</u> Last <u>Gallagher</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/82</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>James A. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Ellen May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr Wilbert F Thompson</u> Address <u>2500 @ St. Wash DC</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest due to Toxicity</u> DUE TO <u>491x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia -</u> DUE TO <u>5 days.</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility ; Chronic Bronchitis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 27</u> , 19 <u>57</u> , to <u>Nov 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>57</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilford D Meyers</u> M.D. <u>8323 Haddon Drive Takoma Park</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers MD</u>		22. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>11/29/57</u>	
22c. LOCATION (City, town, or county) (State) <u>Huntington, West Va.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.</u>	
24a. RECEIVED BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patter</u>	

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12083

CERTIFICATE OF DEATH

12063

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Gates		4. DATE OF DEATH Month November Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/65
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gates		14. MOTHER'S MAIDEN NAME Laura Burriss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and Uremia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) Gangrene of Right Foot and Leg DUE TO (c) Obliterated Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 11/18/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/15, 1957 , to 11/19, 1957 , that I last saw the deceased alive on 11/18, 1957 , and that death occurred at 6:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/21/57			
ACTUAL SIGNATURE C. H. Ligon		M.D. Sandy Spring, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/22/57	
22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lawley	

NOTES

0115

BUREAU V. S.

NOV 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

Item 18c, Film G-223

Item 21, Film G223 12-9-57 et

12064

12084

12/16/57

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pethesda				c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5913 Green Tree Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Joan Gibala				4. DATE OF DEATH Month Day Year November 28 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1919	
9. AGE (In years lost birthday) yrs. 38		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Pope Webb			
14. MOTHER'S MAIDEN NAME Georgia McNeilly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 861-27-3288				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestines to liver DUE TO (c) Carcinoma of liver INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 2 moa. 8 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 13, 19 57 , to November 28, 19 57 , that I last saw the deceased alive on November 28, 19 57 , and that death occurred at 10:00 P. M. , from the causes and on the date stated above. 9:57 P. M. ADDRESS (Street, city or town, state) DATE SIGNED Allen D. Goodman MD. M.D. The Clinical Center 11/29/57 The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/8/57		Arlington National		Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 12-2-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Loompason							

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PREVIOUS DEATHS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF ARCHIVIST [Illegible]	

RECEIVED
 DEC 5 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12085

CERTIFICATE OF DEATH

Reg. Dist. No. 12065

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 15111 MOUNTAIN LANE			
3. NAME OF DECEASED (Type or print) First Middle Last MAURICE EUGENE GILMORE				4. DATE OF DEATH Month Day Year NOV 19 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 14-1898	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSULTING ENGINEER -SELF		10b. KIND OF BUSINESS OR INDUSTRY KENTUCKY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CYRUS BEATTY GILMORE				14. MOTHER'S MAIDEN NAME ELIZABETH MCQUARRIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) SPANISH AMER.		16. SOCIAL SECURITY NO. NO		17. INFORMANT WIFE Address MRS MARY GILMORE - SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 332x DUE TO Cerebral Infarction Right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Artery Thrombosis DUE TO (c) Cerebral Artery Thrombosis INTERVAL BETWEEN ONSET AND DEATH 23 days 23 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3) Bacterial pneumonia with lung abscess (b) Pulmonary infection							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 491x				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 1 , 1957, to Nov 19 , 1957, that I last saw the deceased alive on Nov 18 , 1957, and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6450 Wisconsin Ave, Bethesda, Md. DATE SIGNED 11/19/57							
ACTUAL SIGNATURE Dr Joseph Kenrick M.D.				PHYSICIAN'S NAME (Type) DR JOSEPH KENRICK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 11-20-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

NOV 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12010

CERTIFICATE OF DEATH

Reg. Dist. No.

12066-13

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 Lee Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Leo</u> Last <u>GLANNON</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>	
11c. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Glannon</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Harrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>498-01-6620</u>	
17. INFORMANT <u>Gladys Glannon, W. Fe</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>3 Previous attacks coronary thrombosis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 30</u> , 19 <u>56</u> , to <u>30 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 Nov</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Queen</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7112 Willow Ave 30 Nov 1957</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>		ADDRESS <u>Takoma Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Pp. Geo. Co., Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Addy</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF CLERK [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	

BURKAV Y. E.

DEC 4 1957

RECEIVED

12086

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles First H. Godbold Jr. Middle John Last				4. DATE OF DEATH Nov. 10 19 57 Month Nov. Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20.75	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fed. Govt				10b. KIND OF BUSINESS OR INDUSTRY Mass.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles H. Godbold Sr.				14. MOTHER'S MAIDEN NAME Mary Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Wife				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Left branch coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, atherosclerosis DUE TO Generalized arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/26 , 19 57 , to 11/10 , 19 57 , that I last saw the deceased alive on 11/9 , 19 57 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Joyee				ADDRESS (Street, city or town, state) 8106 Maple Ridge Rd., Bethesda, Md. DATE SIGNED 11-12-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/11/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Joyee ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR 11-12-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 1930-1931 —

12087

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 4510 Highland Ave.	
3. NAME OF DECEASED (Type or print) First Jack Middle Kaufman Last GOLDSBY		4. DATE OF DEATH Month November Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 November 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Goldsby		14. MOTHER'S MAIDEN NAME Mary Gerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I&II	
17. INFORMANT Wife) Mrs. Lucy H.R. Goldsby (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Hypertensive Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) many (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Nov. , 19 57 , to 19 Nov. , 19 57 , that I last saw the deceased alive on 19 Nov. , 19 57 , and that death occurred at 3:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. Ronald Koons M.D. U.S. Naval Hospital, Bethesda, Md. 11-20-57 PHYSICIAN'S NAME (Type) C. Ronald Koons, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR 11-20-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parselley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, MD, Montgomery County Medical Examiner notified.
Hospital instructed to handle in usual manner.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE	
At Home		Male		45	
4. OCCUPATION		5. MARITAL STATUS		6. DATE OF DEATH	
Teacher		Married		10/25/57	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL	
Heart Disease		Natural		Catholic Cemetery	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	
13. DATE OF REPORT		14. TIME OF REPORT		15. REPORT MADE BY	
10/26/57		10:00 AM		[Name]	

RECEIVED
NOV 21 1957
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

273

12011

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mrs Anne</u> Middle <u>Veronica</u> Last <u>Goode</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		IF UNDER 24 HRS. Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXX Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>XXXXXXX MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Patrick Coyle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute asthmatic bronchitis</u> DUE TO <u>3 days</u> (c) <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 1, 1957</u> , to <u>November 3, 1957</u> , that I last saw the deceased alive on <u>November 3, 1957</u> , and that death occurred at <u>9:46 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u> DATE SIGNED <u>Nov. 3, 1957</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>11/6/57</u> 24b. REGISTRAR'S SIGNATURE <u>William D. Dady</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 6 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12070

12088

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN IB <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilea Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>T</u> Last <u>Gordon Sr</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21-1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>15</u> Hours <u>16</u> Min. <u>34.2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>131-1122882</u>	
17. INFORMANT <u>Eva Gordon</u>		Address <u>3410 Webster St Brentwood</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7, 1957</u> , to <u>Nov. 15, 1957</u> , that I last saw the deceased alive on <u>Nov. 15, 1957</u> , and that death occurred at <u>7:45 P. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John Rogers</u>		M.D. <u>1919</u>	
PHYSICIAN'S NAME (Type) <u>John Rogers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>		24a. REC'D BY REGISTRAR <u>131-1122882</u>	
ADDRESS <u>131-1122882</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patton</u>	
DATE <u>NOV 18 1957</u>			

BUREAU V. S.

NOV 18 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12071

12035

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 1/2 Fayette Street				d. STREET ADDRESS 5 1/2 Fayette Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last BASIL BARRY GREEN				4. DATE OF DEATH Month Day Year November 1, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/82	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min. 4 27	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY NIH		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Leonidas Greene				14. MOTHER'S MAIDEN NAME Mary A. Stonestreet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT 14 Address Mrs Nicholas Brewer Williams Street Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis + coronary insufficiency DUE TO (c) 2 years						INTERVAL BETWEEN ONSET AND DEATH 30 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , to Nov 1 , 19 57 , that I last saw the deceased alive on Oct 30 , 19 57 , and that death occurred at 1 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Linthicum M.D. 256 N. Summit Ave., Bethesda, Md.				DATE SIGNED Nov 1, 1957			
PHYSICIAN'S NAME (Type) William A. Linthicum-Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/57		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR NOV 4 1957		24b. REGISTRAR'S SIGNATURE W. H. Kennedy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John A. Thompson	
Place of Birth		Rockville, Maryland	
Date of Birth		1893	
Sex		Male	
Race		White	
Marital Status		Married	
Date of Death		November 1, 1957	
Place of Death		Rockville, Maryland	
Cause of Death		Heart Disease	
Occupation		Engineer	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Informant		[Signature]	

RECEIVED
BUREAU V. S.
 NOV 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12012

CERTIFICATE OF DEATH

Reg. Dist. No. 12072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>125 Lee Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Grove</u>				4. DATE OF DEATH Month Day Year <u>Nov. 30 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-87</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Western Union Telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>George Grove</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXXXXXXXXXXXXX ELLA LYONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Chark</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Intestinal Obstruction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>?</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus: Fractured Hip-Recent.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-27</u> , 19 <u>57</u> , to <u>11-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-30-57</u> , 19 <u>57</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>		DATE SIGNED <u>11/30/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>K. Warner & Humphrey 8434 9th Ave S.S. Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. EDUCATION [REDACTED]		9. RELIGION [REDACTED]		10. RACE [REDACTED]	
11. CAUSE OF DEATH [REDACTED]		12. MANNER OF DEATH [REDACTED]		13. PLACE OF DEATH [REDACTED]		14. DATE OF DEATH [REDACTED]		15. TIME OF DEATH [REDACTED]	
16. SIGNATURE OF PHYSICIAN [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]		19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF NEXT OF KIN [REDACTED]	

RECEIVED
DEC 4 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12089

12073 2/6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9705 Kingston Rd x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>Kensington, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First Middle Last <u>F Hagerty</u>		4. DATE OF DEATH <u>NOV (27) 1957</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 26 - 1908</u> 9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerty Inc</u>	
11. BIRTHPLACE (State or foreign country) <u>ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robt. SAUL HAGERTY</u>		14. MOTHER'S MAIDEN NAME <u>ALMA Kreuse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wife</u>	
17. INFORMANT <u>Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Myocardial Infarction with Rupture Papillary Muscle</u> DUE TO (c) <u>Coronary Artery Thrombosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>24 hours</u> <u>24 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None</u> 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/3</u> , 19 <u>57</u> , to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 27</u> , 19 <u>57</u> , and that death occurred at <u>10:14 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMAU Chevy Chase MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRINGDALE</u>	22d. LOCATION (City, town, or county) (State) <u>PEORIA ILL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulus Sons</u> ADDRESS <u>1756 P. Ave. Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Reggie Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12074

12013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tobacco Park</u>				c. LENGTH OF STAY IN 1b <u>8 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Wash. Sanitarium & Hospital</u>				d. STREET ADDRESS <u>10013 Reddick Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Moragne</u> Middle <u>Fleming</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-30-98</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>11</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney -- Vet. Adm.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov.</u>			
11. BIRTHPLACE (State or foreign country) <u>America</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>David Edward Hall</u>				14. MOTHER'S MAIDEN NAME <u>Anne Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give way or dates of service) <u>WW #1</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Bertine Hall - wife</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cerebral occlusion</u> DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>NOV 6 1957</u>				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dadd</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____		DECEASED NAME _____ SEX _____ AGE _____ OCCUPATION _____	
PLACE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____		MANNER OF DEATH _____ MEDICAL HISTORY _____ PRESENT ILLNESS _____	
SIGNATURE OF EXAMINER _____ TITLE _____ DATE _____		SIGNATURE OF WITNESS _____ TITLE _____ DATE _____	

BUREAU V. B.

NOV 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12075

12090

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Rockingham			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broadway 83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hazel Middle Lucille Last Halterman				4. DATE OF DEATH Month November Day 22 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1916	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME McKinley Taylor				14. MOTHER'S MAIDEN NAME Bertha Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Carcinoma of the breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 7, 1957 , to November 22, 1957 , that I last saw the deceased alive on November 22, 1957 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-23-57 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Lawrence Schlachter M.D.				PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 11/23/1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Run Brethern Ch.		22d. LOCATION (City, town, or county) (State) Rockingham Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 11-26-57		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

est. 1911

31744

1992

Reynolds M. Reynolds

1. *Die Bedeutung der*

NOV 23 1957

12091

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Pennsylvania b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 107 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2401 Pioneer Avenue			
3. NAME OF DECEASED (Type or print) First Charles Middle David Last Hannah				4. DATE OF DEATH Month November Day 4, Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1935	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Harold R. Hannah				14. MOTHER'S MAIDEN NAME Mary Kocab			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 183-28-6665		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO 355x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hepatolenticular degeneration DUE TO (c) Four years INTERVAL BETWEEN ONSET AND DEATH Two days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 20, 1957, to November 4, 1957 , that I last saw the deceased alive on November 4, 1957 , and that death occurred at 7:20 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/5/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE A. N. Doudoumopoulos M.D.				PHYSICIAN'S NAME (Type) A. N. Doudoumopoulos, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur.-Transit 11/5/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial		22d. LOCATION (City, town, or county) (State) Pittsburgh Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR Park		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50

1

2

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

PLACE OF BIRTH		MARRIAGE		EDUCATION	
Baltimore		None		None	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF DEATH	
July 20, 1927		None		July 20, 1927	
AGE		SEX		RACE	
25 years		Male		White	
PLACE OF DEATH		CITY		COUNTY	
Baltimore		Baltimore		Baltimore	
STREET ADDRESS		CITY		COUNTY	
201 Madison Avenue		Baltimore		Baltimore	
DATE OF DEATH		DATE OF BIRTH		DATE OF DEATH	
July 20, 1927		July 20, 1927		July 20, 1927	
TIME OF DEATH		TIME OF BIRTH		TIME OF DEATH	
11:00 AM		11:00 AM		11:00 AM	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. Smith		J. H. Smith		J. H. Smith	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
July 20, 1927		July 20, 1927		July 20, 1927	

BUREAU V. S.

NOV 8 1927

RECEIVED

12092

CERTIFICATE OF DEATH

12077

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7024 Wisconsin Ave.				d. STREET ADDRESS 7024 Wisconsin Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Byron Last Harvey				4. DATE OF DEATH Month Nov Day 14 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 8		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Tastee Diner		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 161-07-8403		17. INFORMANT Edward M. Warner-Friend		Address 4715 Trent Court Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1917 to 11/14/1957 , that I last saw the deceased alive on 11/11/57 , 19 57 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4709 Montgomery Lane, Bethesda, Md. DATE SIGNED Nov. 15/57							
ACTUAL SIGNATURE Paul D. Cantor M.D.				PHYSICIAN'S NAME (Type) PAUL D. CANTOR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/1957		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 11-16-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
UNKNOWN		M		7		1911		BALTIMORE		MD		USA		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		RACE	
1911-01-01		BALTIMORE		HEART DISEASE		NATURAL		UNKNOWN		UNKNOWN		UNKNOWN		UNKNOWN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 19 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12093

CERTIFICATE OF DEATH

12078

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 3½ days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS c/o Nannie Peters 2 Frederick Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Virginia Last Hatton				4. DATE OF DEATH Month 11 Day 21 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -----/69	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thompson				14. MOTHER'S MAIDEN NAME Margaret Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT 7521 8th St., N. W. Dorothy Bassin Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 447x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) General Arteriosclerosis, Senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1954 , 19 54 , to 11/21 , 19 57 , that I last saw the deceased alive on 11/21 , 19 57 , and that death occurred on 11/21 , 19 57 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg Md. DATE SIGNED Ernest C. Gartner.							
ACTUAL SIGNATURE Ernest C. Gartner. M.D. Gaithersburg Md.							
PHYSICIAN'S NAME (Type) E. C. Gartner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-57		22c. NAME OF CEMETERY OR CREMATORY Clarksburg		22d. LOCATION (City, town, or county) (State) Clarksburg. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg. Md.		24a. REC'D BY REGISTRAR 11-23-57	
				24b. REGISTRAR'S SIGNATURE Gertrude B. Fowler			

CERTIFICATE OF DEATH

217

Name of Deceased Dorothy Bessie Washington, D.C.		Sex Female		Age 38 years		Date of Death October 11, 1957		Place of Death General Hospital, Inc.	
Residence 1100 14th St. N.W., Washington, D.C.		Usual Residence Same as Residence		Cause of Death Myocardial Infarction		Manner of Death Natural		Occupation None	
Signature of Physician [Signature]		Signature of Registrar [Signature]		Signature of Informant [Signature]		Signature of Coroner [Signature]		Signature of Medical Examiner [Signature]	
Date of Birth October 11, 1919		Place of Birth Baltimore, Maryland		Color White		Height 5' 8"		Weight 125 lbs.	
Blood Type B, Rh+		Habit Sobriety		Religion Catholic		Education High School		Marital Status Married	
Previous Illnesses Hypertension, Diabetes		Previous Operations None		Previous Injuries None		Previous Hospitalizations None		Previous Deaths None	
Family History None		Social History None		Occupational History None		Travel History None		Other History None	

BUREAU V. 1

DEC 2 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

12094

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12079

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>702 Dale Dr.</u>		d. STREET ADDRESS <u>702 Dale Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Angus Wood Heishman</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/ 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harrison Heishman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Heltzel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>179-20-7510</u>	
17. INFORMANT <u>Mrs. Valli Walker (daughter) Same # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW OXFORD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEW OXFORD, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Pitter</u>	

MEDICAL CERTIFICATION

RECEIVED

NOV 26 1957

BUREAU V. 3

RECEIVED

12095

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Rural, 15 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Gaithersburg, Rural No3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) First Roy Middle Eugene Last Henderson			4. DATE OF DEATH Month Nov Day 17 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 19-1911		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.		10b. KIND OF BUSINESS OR INDUSTRY Md. State Road Commission Saltville.Va.		11. BIRTHPLACE (State or foreign country) U S A.	
13. FATHER'S NAME William Henderson			14. MOTHER'S MAIDEN NAME Gussie Burgess		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 234-20-9409		17. INFORMANT Helen Louise Henderson, Gaithersburg.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Glissma of Brain DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Md
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. , 19 57 , to Nov 17 , 19 57 , that I last saw the deceased alive on Nov 16 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Luciano I. Leal		ADDRESS (Street, city or town, state) Smithsonburg, Md.		DATE SIGNED md.	
PHYSICIAN'S NAME (Type) Luciano I. Leal					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 19-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
22d. LOCATION (City, town, or county) Rockville, Md.		22e. (State) Md.		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR Nov 20 1957		24b. REGISTRAR'S SIGNATURE Abner G. Cook	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1. NAME OF DECEASED		2. SEX		3. AGE		4. OCCUPATION	
JAMES H. HARRIS		Male		45		Carpenter	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. DATE OF DEATH		8. CAUSE OF DEATH	
Baltimore, Md.		Jan 15, 1857		Jan 15, 1902		Heart Disease	
9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
Baltimore, Md.		10:00 AM		J. H. Harris		J. H. Harris	
13. NAME OF FUNERAL HOME		14. NAME OF MINISTER		15. NAME OF CLERGYMAN		16. NAME OF CHURCH	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
17. NAME OF NEXT OF KIN		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
29. NAME OF WITNESS		30. NAME OF WITNESS		31. NAME OF WITNESS		32. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
45. NAME OF WITNESS		46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
49. NAME OF WITNESS		50. NAME OF WITNESS		51. NAME OF WITNESS		52. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS		56. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
65. NAME OF WITNESS		66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
69. NAME OF WITNESS		70. NAME OF WITNESS		71. NAME OF WITNESS		72. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS		76. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
85. NAME OF WITNESS		86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
89. NAME OF WITNESS		90. NAME OF WITNESS		91. NAME OF WITNESS		92. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS		96. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. H.

NOV 22 1901

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the coroner and to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 6 1/2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4019 Lawrence Avenue		d. STREET ADDRESS 99 W. 39th Street	
3. NAME OF DECEASED (Type or print) First Martha Middle Louise Last HENRY		4. DATE OF DEATH Month November Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1896
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 12 Hours 0 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Robert White McWhiter		14. MOTHER'S MAIDEN NAME Laura Louise Brunner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert M. McWhiter-Brother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead in bed			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 11/1/1957	
22c. NAME OF CEMETERY OR CREMATORY Ocean View		22d. LOCATION (City, town, or county) (State) Oakwood, L. I. New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR 11-2-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		DATE SIGNED November 1, 1957	

RECEIVED

NOV 5 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G222 11-20-57 et

12036

CERTIFICATE OF DEATH

12082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First EUSTACE Middle JEROME Last HILL			4. DATE OF DEATH Month Nov. Day 3 Year 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 20, 1899		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Vernon Hill			14. MOTHER'S MAIDEN NAME Bessie Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Miss Lillian Hill, Falls Rd., Rockville, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3-4 days years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 Nov , 19 57 , to 3 Nov , 19 57 , that I last saw the deceased alive on 2 Nov , 19 57 , and that death occurred at 11 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 809 Viersburg Rd DATE SIGNED Nov 7 57 ACTUAL SIGNATURE H. C. P. AGANZINI M.D. Rockville, Md. PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/57	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sweeney			24a. REC'D BY REGISTRAR DATE NOV 7 57		24b. REGISTRAR'S SIGNATURE W. H. Search

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12083

Reg. Dist. No.

773

12014

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		d. STREET ADDRESS <u>1737 T St. S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Elsie</u> Middle <u>Ruby</u> Last <u>Hinson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1911</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Sanford</u>		14. MOTHER'S MAIDEN NAME <u>Susie A. Foxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Wash. San + Hosp. record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aneurysm of Rupture Circle of Willis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days.</u> <u>? 2 years ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-8-</u> <u>1957</u> , to <u>11-11-</u> <u>1957</u> , that I last saw the deceased alive on <u>11-11-</u> <u>1957</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u> DATE SIGNED <u>11/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lewis</u> ADDRESS <u>Wash D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. W. Lewis</u>			

BUREAU V. 3

NOV 13 1957

RECEIVED

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4516 S. CHELSEA LANE				d. STREET ADDRESS 4516 S. CHELSEA LANE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KARL Middle HOLZHAUER Last HOLZHAUER				4. DATE OF DEATH Month Nov. Day 4 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 29, 1862	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months 2 Days 5		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant (retired)				10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Crist Holzhauser				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen Stoll Address same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Emilia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1957 , to Nov 4, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 6:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Md DATE SIGNED 							
ACTUAL SIGNATURE William T. Joyce, M. D.				M.D. Bethesda, Md			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 11-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 8 1957

BUREAU V. S.

1. NAME OF DECEASED WILLIAM T. JOYCE V. S.		2. SEX M		3. AGE 35		4. DATE OF DEATH OCT 15 1957		5. PLACE OF DEATH BALTIMORE, MARYLAND	
6. OCCUPATION SALES		7. MARITAL STATUS MARRIED		8. EDUCATION HIGH SCHOOL		9. BIRTH DATE JAN 1 1922		10. BIRTH PLACE BALTIMORE, MARYLAND	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. TIME OF DEATH 10:00 AM		14. PLACE OF DEATH HOME		15. SIGNATURE OF DECEASED WILLIAM T. JOYCE	
16. SIGNATURE OF NEXT OF KIN WILLIAM T. JOYCE		17. SIGNATURE OF DECEASED WILLIAM T. JOYCE		18. SIGNATURE OF DECEASED WILLIAM T. JOYCE		19. SIGNATURE OF DECEASED WILLIAM T. JOYCE		20. SIGNATURE OF DECEASED WILLIAM T. JOYCE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12098

CERTIFICATE OF DEATH

Reg. Dist. No.

12085

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Colesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 1238 Colesville-Beltsville Road	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Rebecca Hood		4. DATE OF DEATH Month Day Year November 29 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Norbeck Montgomery County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hammond		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. none	
17. INFORMANT (Daughter) Barbara Broadus		Address Colesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Streptococcal Septicemia 053.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 26 , 19 57 , to Nov 29 , 19 57 , that I last saw the deceased alive on Nov 28 , 19 57 , and that death occurred at 5:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnon H. Trau		M.D. 8237 Georgia Ave. Silver Spring, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED Nov 29 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/57	
22c. NAME OF CEMETERY OR CREMATORY Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DEC 2 1957		24b. REGISTRAR'S SIGNATURE Beaser Thompson	

BUREAU V. S.

DEC 2 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 13 Film G222 11-18-57 et
12099 CERTIFICATE OF DEATH

Reg. Dist. No. 12088

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Office</u> Middle <u>Hoover</u> Last <u>Hoover</u>				4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/15/1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Rose Pendleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Robt. C. Leonard--same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>minutes</u> <u>194/9</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>11/3/57</u> , 19 <u>57</u> , to <u>11/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/3/57</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.				DATE SIGNED <u>11/5/57</u>			
PHYSICIAN'S NAME (Type) <u>Walsh, Bernard</u>				<u>Nash, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 11-6-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>							

BUREAU V. S.

NOV 8 1957

RECEIVED

12100

Item 21 Film 223 11-27-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12087
216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 314 Gorman Avenue			
3. NAME OF DECEASED (Type or print) First Corinne Middle Newhouse Last Howland				4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry S. Brittain				14. MOTHER'S MAIDEN NAME Anna Olive Newhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-38-2939		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190x INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTATIC MALIGNANT MELANOMA DUE TO (c) 6 YEARS.						INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from November 14, 1957 , to November 22, 1957 , that I last saw the deceased alive on November 22, 1957 , and that death occurred at 10:35 a.m. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Richard K. Shaw M.D.				The Clinical Center 11-22-57			
PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial	Nov 25, 1957	Woodlawn Cemetery, Baltimore, Maryland		Bethesda, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Be With Donaldson				24a. REC'D BY REGISTRAR NOV 26 1957		24b. REGISTRAR'S SIGNATURE Jessie Thompson	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12088

12101

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 37 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4887 Battery Lane			
3. NAME OF DECEASED (Type or print) First Walter Middle DeWitt Last Humphrey				4. DATE OF DEATH Month November Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1877	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker				10b. KIND OF BUSINESS OR INDUSTRY Connecticut			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Willis D. Humphrey				14. MOTHER'S MAIDEN NAME Liddie A. Merritt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-01-7472			
17. INFORMATION The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) arteriosclerotic heart disease DUE TO 30 years (c) Interval between onset and death 1-2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, X-radiated post emphysema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from October 14, 1957 to November 20, 1957 that I last saw the deceased alive on November 20, 1957 and that death occurred at 4:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Schlichter				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 11/21/57							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR DATE 1-26-57				24b. REGISTRAR'S SIGNATURE Boris M. Thompson			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Religion		Marital Status		Place of Birth		Date of Birth		Date of Death		Cause of Death		Place of Death	
William A. Morris		Male		37		White		Roman Catholic		Single		The Clinical Center, Bethesda, Md.		November 20, 1957		November 20, 1957		Myocardial Infarction		The Clinical Center, Bethesda, Md.	
Occupation		Education		Previous Illnesses		Medical History		Family History		Social History		Autopsy		Burial		Funeral Home		Physician		Coroner	
None		High School		None		None		None		None		None		None		None		None		None	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Burial		Signature of Funeral		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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NOV 29 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12102

CERTIFICATE OF DEATH

12089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hours 6 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hungerford Middle Hungerford Last Hungerford		4. DATE OF DEATH Month November Day 15 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1957
9. AGE (In years last birthday) NB yrs.		10. AGE (In years last birthday) NB yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Remus Walter Hungerford		14. MOTHER'S MAIDEN NAME Sylvia Janet Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Sylvia J. Haines Rt. #1, Germantown, Md.		Address Rt. #1, Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 776 x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from ----- , 19 ----- , to ----- , 19 ----- , that I last saw the deceased alive on ----- , 19 ----- , and that death occurred at ----- M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ----- DATE SIGNED -----			
ACTUAL SIGNATURE L. I. Leal M.D. -----			
PHYSICIAN'S NAME (Type) L. I. Leal Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16 57	
22c. NAME OF CEMETERY OR CREMATORY Flower Hill		22d. LOCATION (City, town, or county) (State) Red Land Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Proy W Barber		24a. REC'D BY REGISTRAR -----	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Lertinde B Lawler	
DATE 11-17-57		DATE 11-17-57	

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CERTIFICATE OF DEATH

1. NAME OF DECEASED Ruth Walter Humphreys		2. SEX Female		3. RACE White		4. DATE OF BIRTH November 12, 1927		5. PLACE OF BIRTH Baltimore, Md.	
6. DATE OF DEATH November 12, 1957		7. PLACE OF DEATH Baltimore, Md.		8. TIME OF DEATH 11:00 AM		9. CAUSE OF DEATH Heart and		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	

16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERK		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR	

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NOV 26 1957

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11-17-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12103

CERTIFICATE OF DEATH

12090

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Hungerford Last Hungerford				4. DATE OF DEATH Month November Day 13 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/30/09	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Hungerford				14. MOTHER'S MAIDEN NAME Lizzie Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X Deparctic Failure DUE TO Extirpative Biliary Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease (Lymphoma) (c) Neurolytic Anemia							INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May , 19 53 , to Nov. 13 , 19 57 , that I last saw the deceased alive on Nov 13 , 19 57 , and that death occurred at 3:20 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney Md DATE SIGNED 10/13/57							
ACTUAL SIGNATURE Richard A. Yates M.D.				PHYSICIAN'S NAME (Type) Richard, A. Yates, M. D. Olney, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/57		22c. NAME OF CEMETERY OR CREMATORY Gates of Heaven,		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR NOV 18 1957		24b. REGISTRAR'S SIGNATURE Katherine Lawley	

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David Harvey

BUREAU V. S.

NOV 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12104

CERTIFICATE OF DEATH

12091

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>J.</u> Last <u>Huniak</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1924</u>	9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Post</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry J. Huniak</u>				14. MOTHER'S MAIDEN NAME <u>Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs Jennie C. Huniak - Wife</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Hemorrhage</u> 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Hepatitis</u> DUE TO (c) <u>Alcoholism (or Malignancy)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>26 day</u> <u>Many years (Not determined)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>57</u> , to <u>Nov 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>57</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u>				ADDRESS (Street, city or town, state) <u>4413 Bradley Lane</u> DATE SIGNED <u>Nov 15, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Bradley D. Hodgkins, M. D.</u>				<u>Chevy Chase, 15, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 11-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12092

12105 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2602 Ross Road				d. STREET ADDRESS 2602 Ross Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lulu Gibb Hunter				4. DATE OF DEATH Month Day Year November 7, 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/1867		9. AGE (In years lost birthday) yrs. 90	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Gibb				14. MOTHER'S MAIDEN NAME Belinda Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Ch.Ch. Md. Mrs. William T. Ham-2602 Ross Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis (generalized). DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 902.0 senile dementia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell out of bed.		20c. TIME OF INJURY Month, Day, Year Hour a. m. July 20 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Chevy Chase		(County) Md.		(State)	
21. I certify that I attended the deceased from 1952 , 19 52 , to 11/7/57 , 19 57 , that I last saw the deceased alive on 11/4/57 , 19 57 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E.H. Markwood M.D. 3208-17th NW Wash D.C.				DATE SIGNED 11/7/57			
PHYSICIAN'S NAME (Type) E.H. Markwood, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11/8/57		22c. NAME OF CEMETERY OR CREMATORY Tidioute Cemetery		22d. LOCATION (City, town, or county) (State) Tidioute, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St., N.W.				ADDRESS Wash.D.C.		24a. REC'D BY REGISTRAR DATE NOV 12 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12093

12015

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Labama Park</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sydney</u> Middle <u>David</u> Last <u>Hurwitz</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-19</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Jacob Hurwitz</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Bass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Dr. H. Hais (Brother-in-law)</u>		Address <u>9518 Buttrick St. S. S. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Thrombosis</u> DUE TO (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u>lying cause last.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> to <u>Oct. 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 31</u> , 19 <u>57</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Menck</u>		ADDRESS (Street, city or town, state) <u>1730 Ely St. NW</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE MENCK</u>		DATE SIGNED <u>11/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis</u>		ADDRESS <u>3501 N. 1st St.</u>	
24a. REC'D BY REGISTRAR <u>11/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>John D. D.</u>	

BUREAU V. 1

NOV 6 1957

RECEIVED

12106

CERTIFICATE OF DEATH

12094 218
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 1yr. 5mo. 25da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				d. STREET ADDRESS 2746 S. Troy St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ada Nash JACKSON				4. DATE OF DEATH Month Day Year NOV 9 1957			
5. SEX Female		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED		8. DATE OF BIRTH July 10, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Apt. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas J. Nash				14. MOTHER'S MAIDEN NAME Betty Pearn an			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 5 77-05-0489			
17. INFORMANT Asbury Methodist Home - Gaithersburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CANCER - VAGINAL DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 11 months 11 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-19 , 19 56 , to 11-9 , 19 57 , that I last saw the deceased alive on NOV 6 , 19 57 , and that death occurred at 5:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4208 Anthonys St. Kensington, Md 11/9/57							
ACTUAL SIGNATURE Sarah E. Glover				M.D. Nov 12 1957			
PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/57		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St., N.W.				24a. REC'D BY REGISTRAR NOV 12 1957		24b. REGISTRAR'S SIGNATURE Maerda G. Gandy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JACKSON		AGE 45		SEX M		RACE W		DATE OF DEATH NOV 12 1957	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201	
OCCUPATION MANUFACTURER		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH NOV 12 1912		PLACE OF BIRTH BALTIMORE		MOTHER'S NAME JACKSON		FATHER'S NAME JACKSON		SIGNATURE OF DECEASED JACKSON	
DATE OF DEATH NOV 12 1957		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD	
OCCUPATION MANUFACTURER		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH NOV 12 1912		PLACE OF BIRTH BALTIMORE		MOTHER'S NAME JACKSON		FATHER'S NAME JACKSON		SIGNATURE OF DECEASED JACKSON	

NAME OF DECEASED JACKSON		AGE 45		SEX M		RACE W		DATE OF DEATH NOV 12 1957	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201	
OCCUPATION MANUFACTURER		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH NOV 12 1912		PLACE OF BIRTH BALTIMORE		MOTHER'S NAME JACKSON		FATHER'S NAME JACKSON		SIGNATURE OF DECEASED JACKSON	
DATE OF DEATH NOV 12 1957		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD	
OCCUPATION MANUFACTURER		EDUCATION HIGH SCHOOL		MARRIAGE M		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH NOV 12 1912		PLACE OF BIRTH BALTIMORE		MOTHER'S NAME JACKSON		FATHER'S NAME JACKSON		SIGNATURE OF DECEASED JACKSON	

RECEIVED
NOV 12 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12107 CERTIFICATE OF DEATH

Reg. Dist. No. **12095**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
f. STREET ADDRESS 739 Yuma Street, S. E.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Max Middle (None) Last Jacofsky				4. DATE OF DEATH Month November Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 7 Hours 3 Min.		IF UNDER 24 HRS. Months 4 Days 7 Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hyman Jacofsky				14. MOTHER'S MAIDEN NAME Ethel Warshauer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Not available			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 2 hours 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery arteriosclerosis 18 years (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 4, 1957 , to November 23, 1957 , that I last saw the deceased alive on November 23, 1957 , and that death occurred at 4:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-24-57 ACTUAL SIGNATURE J. Richard Crout M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) J. Richard Crout, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/26/1957		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. Cem. Inc		22d. LOCATION (City, town, or county) (State) Hyattsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley S. S. S. S. ADDRESS 4217-9th Xee				24a. REC'D BY REGISTRAR DATE 11-26-57		24b. REGISTRAR'S SIGNATURE Bennett S. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• •

the Clinical Center, Bethesda, Md., 1961.

1939 June Street 3, N. E.

241024

Cap. 11.1.1.1

1998

alternative for

A. Zedler

ES 734970

BUREAU V. B.

The Clinical Center
The National Institute
Roberts J. Nelson

2561 - 62 AGO

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 6 Film 223 11-27-57 et											
12108 CERTIFICATE OF DEATH											
Reg. Dist. No. 216											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NO CHEVY CHASE 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>					d. STREET ADDRESS <u>8806 HAWKINS LANE</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>JENKINS</u>					4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>17</u> Year <u>1957</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/17/57</u>		9. AGE (In years last birthday) yrs. <u>6</u> Min. <u>45</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>NOT GIVEN</u>					14. MOTHER'S MAIDEN NAME <u>DELORES ELAINE JENKINS</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>SAME AS ABOVE</u> <u>CORA HES (GRANDMOTHER)</u>				
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Edema</u> DUE TO (c) <u>Prematurity (7 months)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>6 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. <u>—</u> 19 <u>57</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>11-17</u> , 19 <u>57</u> , to <u>11-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-17</u> , 19 <u>57</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5000 ALTA VISTA RD.</u> DATE SIGNED <u>—</u> ACTUAL SIGNATURE <u>Emilie A. Black</u> M.D. <u>—</u> PHYSICIAN'S NAME (Type) <u>EMILIE H. BLACK</u> <u>BETHESDA MD.</u>											
22a. BURIAL, CREMATION, REBURY (Specify) <u>BURY</u>			22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suroden</u> ADDRESS <u>Rockville, Md.</u>					24a. REC'D BY REGISTRAR <u>NOV 21 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>				

2074232XVI

87

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. PLACE OF DEATH [REDACTED]		6. TIME OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. OCCUPATION [REDACTED]		11. MARITAL STATUS [REDACTED]		12. EDUCATION [REDACTED]	
13. PREVIOUS ILLNESS [REDACTED]		14. MEDICAL HISTORY [REDACTED]		15. SURVIVAL OF OTHERS [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CORONER [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JUDGE [REDACTED]	
22. SIGNATURE OF CLERK [REDACTED]		23. SIGNATURE OF REGISTRAR [REDACTED]		24. SIGNATURE OF ARCHIVIST [REDACTED]	

BUREAU V. B.

NOV 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12109

CERTIFICATE OF DEATH

12097

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington</i> DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7300 Baltimore Ave.</i>		d. STREET ADDRESS <i>7912 West Beach Dr.</i>	
3. NAME OF DECEASED (Type or print) First <i>Estelle</i> Middle <i>Jensen</i> Last <i>Jensen</i>		4. DATE OF DEATH Month <i>NOV.</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 11 1880</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i> Hours <i>57</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hand teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Utah</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Henry C. Jensen</i>		14. MOTHER'S MAIDEN NAME <i>Mary Adeline Graehl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or name of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>7912 W. Beach Dr.</i>	
17. INFORMANT <i>Mrs A C Cooley</i>		Address <i>7912 W. Beach Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>434.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac decompensation</i> DUE TO (c) <i>4 mos</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Nov 22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov 22</i> , 19 <i>57</i> , and that death occurred at <i>9:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Raymond O. West</i>		ADDRESS (Street, city or town, state) <i>7600 Carrace Ave. Takoma Park Md.</i>	
PHYSICIAN'S NAME (Type) <i>RAYMOND O. WEST</i>		DATE SIGNED <i>Nov 22/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL</i>		22b. DATE THEREOF <i>11/26/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>BRIGHAM CITY CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>BRIGHAM CITY, UTAH</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>DATE</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Pattery</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	

DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	

BUREAU V. 8

NOV 26 1957

RECEIVED

DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12110

CERTIFICATE OF DEATH

12098

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 E. Lenox Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookgrove Chronic Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph A.</u> Middle <u>Tonger</u> Last <u>Tonger</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-9, 1862</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>95</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Thomasville-Ga</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Tonger</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Heller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Mrs. Wm Sabine</u>		Address <u>10 E. Lenox Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac distention</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>Nov 4 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18, 1957</u> to <u>Nov 5, 1957</u> , that I last saw the deceased alive on <u>Nov 4, 1957</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. W. Bird</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Olney, Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>[Address]</u>	
24a. REC'D BY REGISTRAR <u>Nov 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

Page One, No.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1912</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>	
7. DATE OF DEATH <i>Nov 10 1957</i>		8. PLACE OF DEATH <i>Home</i>		9. CAUSE OF DEATH <i>Myocardial Infarction</i>	
10. MEDICAL HISTORY <i>None</i>		11. OCCUPATION <i>Engineer</i>		12. EDUCATION <i>High School</i>	
13. MARITAL STATUS <i>Married</i>		14. NAME OF SPOUSE <i>Jane Doe</i>		15. DATE OF MARRIAGE <i>1935</i>	
16. NAME OF PHYSICIAN <i>Dr. J. Smith</i>		17. NAME OF HOSPITAL <i>None</i>		18. NAME OF FUNERAL HOME <i>None</i>	
19. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF WITNESSES <i>[Signatures]</i>	
22. DATE OF SIGNATURE <i>Nov 10 1957</i>		23. PLACE OF SIGNATURE <i>Home</i>		24. NAME OF REGISTRAR <i>[Name]</i>	
25. DATE OF REGISTRATION <i>Nov 10 1957</i>		26. PLACE OF REGISTRATION <i>Home</i>		27. NAME OF COUNTY CLERK <i>[Name]</i>	
28. DATE OF CLERK'S SIGNATURE <i>Nov 10 1957</i>		29. PLACE OF CLERK'S SIGNATURE <i>Home</i>		30. NAME OF COUNTY CLERK <i>[Name]</i>	

BUREAU V. E.

NOV 7 1957

RECEIVED

12016

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 7701 Georgia Ave. N.W.			
3. NAME OF DECEASED (Type or print) First Thomas Middle Wilmer Last Johnson				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male				6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/28/85				9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Treasurer				10b. KIND OF BUSINESS OR INDUSTRY Credit Union		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Aquila Johnson				14. MOTHER'S MAIDEN NAME Dowell —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infants, multiple, lungs DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolic thrombi, pulmonary arteries (c) Mucous adenocarcinoma, head of pancreas							INTERVAL BETWEEN ONSET AND DEATH few days " " about 1 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 13, 1957 to Nov 1, 1957 , that I last saw the deceased alive on Oct 30, 1957 , and that death occurred at 3:16 M, from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE George L Ball				M.D. 7835 Eastern Ave			
PHYSICIAN'S NAME (Type) George L Ball				Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF NOV. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		22d. LOCATION (City, town, or county) (State) SUITLAND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong				ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR Nov 4 1957	
				24b. REGISTRAR'S SIGNATURE J. M. Hysong			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

District of Columbia

Washington

1101 Georgia Ave. N.W.

Nov 1 1957

6/28/82

A. E. H.

Maryland

Dowell

Hospital Records

Male White

Retired Treasurer

Adella Johnson

Unknown

BUREAU V. 1

NOV 4 1957

RECEIVED

CREMATION NOV. 1957 CEDAR HILL CEMETERY
WASH. D. C.
200 N. 21ST

121111

CERTIFICATE OF DEATH

12100

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rockville 26</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>401 West Montgomery Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles M Jones</u>				4. DATE OF DEATH Month Day Year <u>Nov. 23, 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maryland State Governor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cecilton Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Charles B Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Mace (?)</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT Address <u>Edmond A. Jones 3006 N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Strangulated inguinal hernia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/18/</u> 19 <u>57</u> to <u>11/23/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/23/</u> 19 <u>57</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Edwin Mc Namara</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1801 Eye St. Wash. D.C. Nov. 23, 1957</u>			
PHYSICIAN'S NAME (Type) <u>C. EDWIN Mc NAMARA</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>11-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Skompton</u>	

CERTIFICATE OF DEATH

Reg. 2001, 1957

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

NOV 29 1957

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Continuation of the death certificate form, containing additional fields for medical history, autopsy, and certification. It includes a large section for the certifying physician's signature and stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112

CERTIFICATE OF DEATH

12101

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 815 HOLLYWOOD AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERBERT Middle CARSON Last JONES, SR.				4. DATE OF DEATH Month Nov. Day 5 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/99	9. AGE (In years and birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.		11. BIRTHPLACE (State or foreign country) Norton, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Banner Jones				14. MOTHER'S MAIDEN NAME Dora B. Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 339-09-0864		17. INFORMANT Address Mrs. Dorothy B. Jones, 815 Hollywood Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 443x DUE TO Hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) auricular fibrillation; congestive heart failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring, Md.	20f. (City or town) Silver Spring, Md.	(County) Montgomery	(State) Md.		
21. I certify that I attended the deceased from 1946 , 19 Nov. , 19 57 , that I last saw the deceased alive on 25 - October , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above.							DATE SIGNED 1746 - K Sh. N. W. Wark, Jr. 5-2-57
ACTUAL SIGNATURE George W. Lewis		M.D. 1746 - K Sh. N. W. Wark, Jr. 5-2-57					
PHYSICIAN'S NAME (Type) Warner B. Humphrey							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY HYLAND CEMETERY		22d. LOCATION (City, town, or county) (State) NORTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 8 1957	24b. REGISTRAR'S SIGNATURE Frances Petty		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12113 CERTIFICATE OF DEATH

12102

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda - Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle J Last Keeley				4. DATE OF DEATH Month NOV Day 25 Year 1957			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7 1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Gen. Mgr. Fruit Growers Express				10b. KIND OF BUSINESS OR INDUSTRY New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John F. Keeley				14. MOTHER'S MAIDEN NAME Jenny Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Wife (Mary Keeley) Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary carcinoma of parotid DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 5 mo 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1930 to Nov. 25 1957, that I last saw the deceased alive on Nov. 24 1957, and that death occurred at 135 p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul N. Taylor M.D. 2140 Pa. Ave. N.W. Wash. D.C.				DATE SIGNED			
PHYSICIAN'S NAME (Type) PAUL N. TAYLOR M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Harris Co. ADDRESS 2201 - 14th St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR 27 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

Page 1 of 1

PLACE OF DEATH		MARRIAGE	
1. Name of deceased		2. Name of spouse	
3. Date of death		4. Date of marriage	
5. Place of death		6. Place of marriage	
7. Cause of death		8. Manner of death	
9. Name of physician		10. Name of funeral director	
11. Name of informant		12. Signature of informant	
13. Date of completion		14. Signature of registrar	
15. Name of registrar		16. Signature of registrar	
17. Name of registrar		18. Signature of registrar	
19. Name of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar	
23. Name of registrar		24. Signature of registrar	
25. Name of registrar		26. Signature of registrar	
27. Name of registrar		28. Signature of registrar	
29. Name of registrar		30. Signature of registrar	
31. Name of registrar		32. Signature of registrar	
33. Name of registrar		34. Signature of registrar	
35. Name of registrar		36. Signature of registrar	
37. Name of registrar		38. Signature of registrar	
39. Name of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar	
43. Name of registrar		44. Signature of registrar	
45. Name of registrar		46. Signature of registrar	
47. Name of registrar		48. Signature of registrar	
49. Name of registrar		50. Signature of registrar	
51. Name of registrar		52. Signature of registrar	
53. Name of registrar		54. Signature of registrar	
55. Name of registrar		56. Signature of registrar	
57. Name of registrar		58. Signature of registrar	
59. Name of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar	
63. Name of registrar		64. Signature of registrar	
65. Name of registrar		66. Signature of registrar	
67. Name of registrar		68. Signature of registrar	
69. Name of registrar		70. Signature of registrar	
71. Name of registrar		72. Signature of registrar	
73. Name of registrar		74. Signature of registrar	
75. Name of registrar		76. Signature of registrar	
77. Name of registrar		78. Signature of registrar	
79. Name of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar	
83. Name of registrar		84. Signature of registrar	
85. Name of registrar		86. Signature of registrar	
87. Name of registrar		88. Signature of registrar	
89. Name of registrar		90. Signature of registrar	
91. Name of registrar		92. Signature of registrar	
93. Name of registrar		94. Signature of registrar	
95. Name of registrar		96. Signature of registrar	
97. Name of registrar		98. Signature of registrar	
99. Name of registrar		100. Signature of registrar	

Handwritten notes:
Cause of death: ...
Manner of death: ...
Name of physician: ...
Name of funeral director: ...

BUREAU V. S.

NOV 27 1957

RECEIVED

12114

CERTIFICATE OF DEATH

12103

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>WESTMORELAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>7 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>231 WEST-MORELAND AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUSTINE BERNARD KELLEY</u>				4. DATE OF DEATH Month Day Year <u>NOV 20 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 9-1883</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>4 11</u>		IF UNDER 24 HRS. <u>4 11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. REPRESENTATIVE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONGRESS</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ABRAHAM KELLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH KEOG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>3 YRS WEST POINT</u>				16. SOCIAL SECURITY NO. <u>207-09-936</u>		17. INFORMANT <u>SON</u> Address <u>JAMES R. KELLEY - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X DUE TO UREMIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA BLADDER E</u> <u>8 MONTHS</u> (c) <u>WIDESPREAD METASTASIS</u> <u>2 MONTHS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYO CARDIAL INFARCTION, ANTERIOR, OLD</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUGUST, 1957</u> , to <u>11/20, 1957</u> , that I last saw the deceased alive on <u>11/20, 1957</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 BATTERY LA</u> DATE SIGNED <u>11/20/57</u>							
ACTUAL SIGNATURE <u>Charles J. Savarese Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE JR.</u> <u>BETHESDA, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 11/20/57</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY <u>Arlington Nat'l Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 1-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	

BUREAU V. S.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12104

273

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>3127 18th St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>ELLEN</u> Last <u>LANHAM</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stack</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hospital Records - W.S. & H.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma metastatic in lung</u> 194X DUE TO <u>Probably primary in thyroid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>57</u> , to <u>11-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-11</u> , 19 <u>57</u> , and that death occurred at <u>4:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.W. DANISH</u>		ADDRESS (Street, city or town, state) <u>927 Pershing Rd. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>		DATE SIGNED <u>11-12-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>15 Nov 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halpern Funeral Home Inc.</u>		ADDRESS <u>1000 Rainier, S.W.</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 14 1957

BUREAU V. S.

NOV 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12105

12115

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 83 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chevy Chase	
4. DATE OF DEATH First Lawrence Middle Augustin Last Lawlor		5. DATE OF DEATH Month November Day 15 Year 1957	
6. SEX Male		7. COLOR OR RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH February 3, 1888	
10. AGE (In years last birthday) 69		11. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Legal Profession	
13. BIRTHPLACE (State or foreign country) Massachusetts		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME James Lawlor		16. MOTHER'S MAIDEN NAME Elizabeth Whelan	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. Unascertainable	
19. INFORMANT The Medical Record		20. ADDRESS The Clinical Center, Bethesda 14, Maryland	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, acute, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, epidermoid, laryngeal area, metastatic to lungs, liver, pleura. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe generalized arteriosclerosis. Pericarditis, acute.		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
26. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		27. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29. (City or town) (County) (State)	
30. I certify that I attended the deceased from August 24, 1957 , to November 15, 1957 , that I last saw the deceased alive on November 15, 1957 , and that death occurred at 12:15p M. from the causes and on the date stated above.			
31. ACTUAL SIGNATURE Theodore Robinson		32. ADDRESS (Street, city or town, state) The Clinical Center	
33. PHYSICIAN'S NAME (Type) THEODORE ROBINSON, M. D.		34. DATE SIGNED 11/15/57	
35. BURIAL, CREMATION, REMOVAL (Specify) Burial		36. DATE THEREOF 11/18/57	
37. NAME OF CEMETERY OR CREMATORY Gate of Heaven		38. LOCATION (City, town, or county) (State) XXXXXXX Aspen Hills, Md	
39. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		40. ADDRESS Bethesda 14, Maryland	
41. REC'D BY REGISTRAR 11-16-57		42. REGISTRAR'S SIGNATURE Beard M. Thompson	

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH		AGE	
Maryland		1900		10 years	
PLACE OF DEATH		DATE OF DEATH		CAUSE OF DEATH	
Baltimore, Maryland		November 12, 1957		Influenza, pneumonia, complications	
PLACE OF INTERMENT		DATE OF INTERMENT		CITY OF INTERMENT	
Baltimore, Maryland		November 15, 1957		Baltimore, Maryland	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN	
The Baltimore Funeral Home		Rev. J. J. Jones		Rev. J. J. Jones	
NAME OF WITNESSES		NAME OF REGISTRAR		NAME OF CLERK	
John Doe, Jane Doe		J. J. Jones		J. J. Jones	

BUREAU V. S.

NOV 19 1957

RECEIVED

12116 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7101 Eu fair Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jules</u> Middle <u>GIRARDAN</u> Last <u>Leicester</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1896</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Galverston Texas</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>? UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>CECILE GIRARDAN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Annie F Leicester, 7101 Eu fair Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO <u>5 YEARS</u> (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO <u>5 YEARS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Nov. 9, 1955</u> , to <u>Nov. 9, 1957</u> , that I last saw the deceased alive on <u>Nov. 9, 1957</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip R. James</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington Clinic Nov. 9, 1957</u> <u>Wisc. & Western Aves. N.W.</u> <u>Washington, D. C.</u>			
PHYSICIAN'S NAME (Type) <u>Philip R. James</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Catholic</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. C. Lamphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 11-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Beessie M. Thompson</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5110

Rev. Oct. 1955

<p>1. DECEASED'S NAME (Last, first, middle initial) _____</p>		<p>2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. AGE (in years and months) _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. OCCUPATION _____</p>		<p>8. CAUSE OF DEATH (as certified by physician) _____</p>	
<p>9. MANNER OF DEATH (as certified by physician) _____</p>		<p>10. SIGNATURE OF PHYSICIAN _____</p>	
<p>11. SIGNATURE OF REGISTRAR _____</p>		<p>12. DATE OF DEATH _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF WITNESS _____</p>	

BUREAU V. 3

NOV 13 1957

RECEIVED

Galveston

Id. Catholic

12/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12107

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 5033 Bradley Blvd. Apt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Louise Middle Lincoln Last				4. DATE OF DEATH Nov. 29, 1957 Month Nov. Day 29 Year 19				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/7/09		
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper			10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phellis Cary Mitchell				14. MOTHER'S MAIDEN NAME Ada Rebecca Borden				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Record Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage and Laceration 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Bullet wound thru skull DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 22 hrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported playing "Russian Roulette"						
20c. TIME OF INJURY Month, Day, Year 8:30 11/28/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) house		20f. (City or town) (County) (State) Chevy Chase Montg. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschert M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/29/57				
22a. BURIAL, CREMATION, or DISPOSAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.		22d. LOCATION (City, town, or county) (State) Middletown, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-2-57		
				24b. REGISTRAR'S SIGNATURE Bessie L. Thompson				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Clinical History		Gross Findings	
Microscopic Findings		Bacteriologic Findings		Chemical Findings		Other Findings	
Diagnosis		Contributing Causes		Immediate Cause		Underlying Cause	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Family	

BUREAU V. S.

DEC 5 1957

RECEIVED

Office of the Registrar
Dec 11, 1957
M. J. Connelley

12118

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1 Wicomico Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Kirb</u> Middle <u>Benjamin</u> Last <u>Litten</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Litten Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-20-073</u>			
17. INFORMANT <u>Anna Mae George</u>				Address <u>RI Mt Jackson, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Confluent Bronchopneumonia</u> DUE TO <u>with abscesses formation.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 26</u> , 1957, to <u>Nov 29</u> , 1957, that I last saw the deceased alive on <u>Nov 29</u> , 1957, and that death occurred at <u>9:42 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Arnon H. Trauer</u>				M.D. <u>8237 Georgia Ave Silver Spring Md Nov 30/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Ch.</u>		22d. LOCATION (City, town, or county) (State) <u>Edinburg Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chas. Fuernberg (Home) Wash. D.C.</u>				ADDRESS <u>5100 Wisconsin Ave</u>		24a. REC'D BY REGISTRAR <u>DEG 3 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

121119

Item 9 Film G223 12-12-57 et

CERTIFICATE OF DEATH

12109

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WINIFRED BEAL</u> <u>HOWE</u>		4. DATE OF DEATH Month Day Year <u>November 30</u> , 19 <u>57</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 28 1882</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS, Cambridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT E BEAL</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE BEAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>579-28-6543</u>	
17. INFORMANT Address <u>GLEN ECHO, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS and</u> DUE TO <u>DIABETES MELLITUS</u> (c) <u>1 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>57</u> , to <u>Nov 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo I Donovan MD</u>		DATE SIGNED <u>11/30/57</u>	
PHYSICIAN'S NAME (Type) <u>LEO I DONOVAN MD</u>		ADDRESS (Street, city or town, state) <u>BETHESDA 14 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>Dec. 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>		ADDRESS <u>3072 M ST NW Washington DC</u>	
24a. REC'D BY REGISTRAR <u>13</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	
DATE <u>3</u>		1957	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12110

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6312 Toner Dr</u>		d. STREET ADDRESS <u>6312 Toner Dr</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Jennifer Alice Mann</u>		4. DATE OF DEATH <u>Nov 9 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-57</u>
9. AGE (in years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM Mann</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Susser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>WM Mann (father)</u>		Address <u>Same # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475x Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 11, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ring David Maus Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Gargursky & Sons</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 1-13-67</u>		24b. REGISTRAR'S SIGNATURE <u>Bernice M. Thompson</u>	

90000000X00

RECEIVED

NOV 15 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
2130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
IMMEDIATE CAUSE: [illegible]
UNDERLYING CAUSE: [illegible]
MORBIDITY: [illegible]
MORTALITY: [illegible]
DIAGNOSIS: [illegible]
HISTORICAL: [illegible]
PHYSICAL: [illegible]
LABORATORY: [illegible]
TOPOGRAPHICAL: [illegible]
SOCIAL: [illegible]
OCCUPATIONAL: [illegible]
EDUCATIONAL: [illegible]
RELIGIOUS: [illegible]
POLITICAL: [illegible]
ECONOMIC: [illegible]
CULTURAL: [illegible]
LEGAL: [illegible]
MEDICAL: [illegible]
NURSING: [illegible]
DENTAL: [illegible]
PHARMACEUTICAL: [illegible]
VETERINARY: [illegible]
AERONAUTICAL: [illegible]
ASTRONOMICAL: [illegible]
COSMETOLOGICAL: [illegible]
DIESEL: [illegible]
ELECTRICAL: [illegible]
ENGINEERING: [illegible]
FARMING: [illegible]
FISHING: [illegible]
FORESTRY: [illegible]
GEODESIC: [illegible]
GEOMETRICAL: [illegible]
GEOPHYSICAL: [illegible]
GEOLOGICAL: [illegible]
GEOGRAPHICAL: [illegible]
HISTORICAL: [illegible]
JURIDICAL: [illegible]
LITERARY: [illegible]
MATHEMATICAL: [illegible]
METEOROLOGICAL: [illegible]
MINERALOGICAL: [illegible]
MUSICAL: [illegible]
NATURAL: [illegible]
PHYSICAL: [illegible]
POLITICAL: [illegible]
PSYCHOLOGICAL: [illegible]
RELIGIOUS: [illegible]
SCIENTIFIC: [illegible]
SOCIAL: [illegible]
STATISTICAL: [illegible]
TECHNICAL: [illegible]
THEATRICAL: [illegible]
ZOOLOGICAL: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

CERTIFICATE OF DEATH

12111

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 201 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 (Washington 16)			
f. STREET ADDRESS 5609 Namakagan Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bernard Middle Edward Last MANSEAU				4. DATE OF DEATH Month November Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 October 1899		9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gideon MANSEAU				14. MOTHER'S MAIDEN NAME Emma (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-03-22 to 7-31-57		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Address Mrs. Dorothy M. MANSEAU (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 260x (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and Diverticulum of duodenum						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 April , 19 57 , to 4 November , 19 57 , that I last saw the deceased alive on 4 November , 19 57 , and that death occurred at 6:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thirl E. Jarrett M.D. U.S. Naval Hospital, Bethesda, Md. 11-5-57							
ACTUAL SIGNATURE Thirl E. Jarrett							
PHYSICIAN'S NAME (Type) Thirl E. Jarrett, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers, 3072 M. Street, NW, Washington, D.C.				24a. REC'D BY REGISTRAR 11-5-57			
24b. REGISTRAR'S SIGNATURE Mary B. Casully							

1

12122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12122 CERTIFICATE OF DEATH

12112/4
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Iowa</u> b. COUNTY <u>Benton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3508 Anderson</u>				d. STREET ADDRESS <u>none</u>			
3. NAME OF DECEASED (Type or print) <u>XXXXXX</u> First <u>BERT</u> Middle <u>A.</u> Last <u>MARKHAM</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26, 1876</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>		IF UNDER 24 HRS. Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u>		11. BIRTHPLACE (State or foreign country) <u>Vinton, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles Marchmont</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Quackenbush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>478-24-8064</u>		17. INFORMANT <u>Mrs Elaine Sweeney</u> Address <u>Kensington, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 13, 1957</u> to <u>Nov. 15, 1957</u> that I last saw the deceased alive on <u>Nov. 14, 1957</u> , and that death occurred at <u>12:10</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.				ADDRESS (Street, city or town, state) <u>9241 Col. Blvd. Silver Spring, Md</u>			
DATE SIGNED <u>11/15/57</u>							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>11/16/57</u>		<u>EVERGREEN CEMETERY</u>		<u>VINTON, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12018

CERTIFICATE OF DEATH

12113/13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>3 1/2 hr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash Sanitarium & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Gilbert</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-17</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst Foreman, Machine shop</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gilbert F Marshall</u>	
14. MOTHER'S MAIDEN NAME <u>Sadie Plum</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW, Army</u>		16. SOCIAL SECURITY NO. <u>047-07-4192</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure, Acute</u> 420.1 DUE TO <u>Coronary Thrombosis (New)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary Thrombosis (Old)</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 13, 1957</u> to <u>Nov 13, 1957</u> , that I last saw the deceased alive on <u>Nov 13, 1957</u> , and that death occurred at <u>6:27 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>7835 Eastern Ave, Silver Spring, Md</u> DATE SIGNED <u>Nov 13, 1957</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>11/16/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Perkins Chapel Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Springfield, Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>			
24a. REC'D BY REGISTRAR <u>NOV 18 1957</u>				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Paddy</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Nov 13, 1957

Dr Broschart was contacted re: the
the circumstances of the death
and he authorized me to sign
the certificate

John V. Bell

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12123

Item 7 FilmG223 12-12-57 et

CERTIFICATE OF DEATH

12114

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 14863 BATTERY LANE	
3. NAME OF DECEASED (Type or print) First Andrew Middle McCallum Last McCallum		4. DATE OF DEATH Month 11 Day 15 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG 25-1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE IND.	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT FRIEND Address CORA GLEBAN - 8011 PARK LANE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premia 442X DUE TO Cardiovascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 442X DUE TO Cardiovascular Renal Disease c) 442X DUE TO Cardiovascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11, 1957 , to Nov. 15, 1957 , that I last saw the deceased alive on Nov. 15, 1957 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Roberts M.D.		ADDRESS (Street, city or town, state) 8907 Geo. Ave Silver Spring DATE SIGNED 11/15/1957	
PHYSICIAN'S NAME (Type) James Roberts, M.D.		8907 Georgia Avenue, Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE 12-2-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

15153

PLACE OF DEATH		MARRIAGE	
LOCALITY		DATE OF MARRIAGE	
COUNTY		STATE	
CITY		CITY	
STREET		STREET	
APARTMENT		APARTMENT	
DECEASED		DECEASED	
NAME		NAME	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF BURIAL		PLACE OF BURIAL	
DATE OF BURIAL		DATE OF BURIAL	
TIME OF BURIAL		TIME OF BURIAL	
NAME OF BURIAL		NAME OF BURIAL	
ADDRESS OF BURIAL		ADDRESS OF BURIAL	
CITY OF BURIAL		CITY OF BURIAL	
STATE OF BURIAL		STATE OF BURIAL	
COUNTRY OF BURIAL		COUNTRY OF BURIAL	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
COUNTY		COUNTY	
CITY		CITY	
STREET		STREET	
APARTMENT		APARTMENT	
DECEASED		DECEASED	
NAME		NAME	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF BURIAL		PLACE OF BURIAL	
DATE OF BURIAL		DATE OF BURIAL	
TIME OF BURIAL		TIME OF BURIAL	
NAME OF BURIAL		NAME OF BURIAL	
ADDRESS OF BURIAL		ADDRESS OF BURIAL	
CITY OF BURIAL		CITY OF BURIAL	
STATE OF BURIAL		STATE OF BURIAL	
COUNTRY OF BURIAL		COUNTRY OF BURIAL	

BUREAU V. 2

8801 Georgia Avenue, N.W. DEC 18, 1957

RECEIVED

12124

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 111 NEWLAND ST	
3. NAME OF DECEASED (Type or print) MARY First WILLIAM Middle MCCARTHY Last		4. DATE OF DEATH NOV 9 Month 9 Day 1957 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-76
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Fauquier Co Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Freeman		14. MOTHER'S MAIDEN NAME Bethy M. McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Martin McCarthy		Address 111 Newland St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Antenatal heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-27 , 19 57 , to 11-9 , 19 57 , that I last saw the deceased alive on 11-9 , 19 57 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph A. Bulzyn		ADDRESS (Street, city or town, state) Wash. D.C.	
PHYSICIAN'S NAME (Type) Wash. D.C.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Gladesburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		ADDRESS 4812 Ga. ave. N.W.	
24a. RECEIVED BY REGISTRAR NOV 13 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the return prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
CAUSE OF DEATH		IMMEDIATE		IMMEDIATE		IMMEDIATE		IMMEDIATE		IMMEDIATE		IMMEDIATE		IMMEDIATE	
DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE	
SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS		SYMPTOMS	
TREATMENT		TREATMENT		TREATMENT		TREATMENT		TREATMENT		TREATMENT		TREATMENT		TREATMENT	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 1

NOV 15 1957

RECEIVED

12019

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>Hyattsville Md. 1615.2</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gerald W. McCombs</u>				4. DATE OF DEATH Month Day Year <u>11 30 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1907</u>	
				9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter (Naval Research Lab.)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kent, Ohio</u>	
13. FATHER'S NAME <u>Noble McCombs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1925-1932</u>				16. SOCIAL SECURITY NO. <u>577-12-3762</u>		17. INFORMANT Address <u>Mrs. Regina McCombs, 7906 25th Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (acute) 420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recurrent Hypertension w/ rt Kidney (removed)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carr. 22 Ave</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Raymond O. West</u> M.D. <u>Takoma Park Md.</u> PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 4th Ave S.S.</u>				24a. REC'D BY REGISTRAR <u>MD</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dadds</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Deputy Medical Examiner notified and will approve. R. O. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12125

CERTIFICATE OF DEATH

12117

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS 8821-Ridgerd!	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Josephine McCormick		4. DATE OF DEATH Month Day Year NOV 1 1957	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23 - 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Michael Burk McCormick		14. MOTHER'S MAIDEN NAME ANNA Tuohy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MRS Andrew C. Auth - (Above)		Address Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO Senility (c) Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Nov 1, 1957 that I last saw the deceased alive on Nov 1, 1957 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda, Md. 11/2/57			
ACTUAL SIGNATURE W. T. Joyce		M.D. 8106 Maple Ridge Rd., Bethesda, Md.	
PHYSICIAN'S NAME (Type) W. T. JOYCE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 1-4-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

NOV 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12126 CERTIFICATE OF DEATH

12118
274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWPORT 75 x - 3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2721 DAWSON AVENUE		d. STREET ADDRESS 38 South 2nd Street	
3. NAME OF DECEASED (Type or print) First <i>Wm. Mary</i> Middle <i>Sarah</i> Last <i>McNitt</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>28</i> Year <i>1957</i>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 14, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) LOYSVILLE, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAM HEIM		14. MOTHER'S MAIDEN NAME ELMIRA KENNEDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Capt. Wm. H. McNitt, 2721 Dawson Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>acute myocardial infarction</i> DUE TO (b) <i>chronic myocardial disease</i> DUE TO (c) <i>generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr 2 years 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1957 to Nov 28, 1957 , that I last saw the deceased alive on Nov 19, 1957 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John S. Rogers</i> M.D.		ADDRESS (Street, city or town, state) 1919 Lemmon Ave. West, Md.	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		DATE SIGNED <i>Liles G. G. G.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/1/57	
22c. NAME OF CEMETERY OR CREMATORY Loysville Cemetery		22d. LOCATION (City, town, or county) (State) Loysville, Perry County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 29 1957	
		24b. REGISTRAR'S SIGNATURE <i>Frances Patten</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		SUICIDE		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	

BUREAU V. S.

NOV 29 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12127
 CERTIFICATE OF DEATH

Reg. Dist. No.

12119
 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE #4 SUNNYSIDE ROAD. b. COUNTY SILVER SPRING MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS #4 SUNNYSIDE ROAD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANCIS MC PROUTY.		4. DATE OF DEATH Month Day Year 11/26/57 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/98
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER		10b. KIND OF BUSINESS OR INDUSTRY ICE CREAM.	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM L. MC PROUTY		14. MOTHER'S MAIDEN NAME NORA CAMPBELL.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT LILLIAN MC PROUTY.		Address WIFE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Sigmoid Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with generalized metastasis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3-6-1957 to 11-26-57			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-21- , 19 49 , to 11-26- , 19 57 , that I last saw the deceased alive on N ov. 23, 19 57 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		322 H Street, N.E. Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/30/57	22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY.	22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.K. HUNTERMAN & SON		24a. REG'D BY REGISTRAR DEC 3 1957	
ADDRESS 5732 GEORGIA AVE		24b. REGISTRAR'S SIGNATURE Francis Patten	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF MENTAL HEALTH PROFESSIONAL		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. 1

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

CERTIFICATE OF DEATH

Reg. Dist. No.

12120 7

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Thompson Road</u>				d. STREET ADDRESS <u>Thompson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVART</u> Middle <u>BRYANT</u> Last <u>MELENDY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>7.</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Organ Repairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organs</u>		11. BIRTHPLACE (State or foreign country) <u>Battle Creek, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Bryant Hutchinson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Janette Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>290-30-1011</u>		17. INFORMANT <u>Mrs. Nettie Melendy, (same as item #2)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Alcohol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Insanition</u> DUE TO <u>Insanition</u> (c) <u>Test Carcinoma Prostate & Metast.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mo.</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan. 25, 1957</u> , to <u>Nov. 7, 1957</u> , that I last saw the deceased alive on <u>Oct. 31, 1957</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. McNeill</u>				ADDRESS (Street, city or town, state) <u>Takoma Park</u>		DATE SIGNED <u>11/7/57</u>	
PHYSICIAN'S NAME (Type) <u>W. F. McNeill, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St. NW</u>		24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>							

CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. PLACE OF DEATH	
3. DATE OF BIRTH		4. DATE OF DEATH	
5. SEX		6. RACE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. MEDICAL HISTORY	
11. PRESENT ILLNESS		12. PREVIOUS ILLNESSES	
13. TREATMENT		14. PHYSICIAN'S SIGNATURE	
15. CORONER'S SIGNATURE		16. COUNTY CLERK'S SIGNATURE	
17. DATE OF DEATH		18. TIME OF DEATH	
19. PLACE OF DEATH		20. NAME OF DECEASED	
21. NAME OF DECEASED		22. NAME OF DECEASED	
23. NAME OF DECEASED		24. NAME OF DECEASED	
25. NAME OF DECEASED		26. NAME OF DECEASED	
27. NAME OF DECEASED		28. NAME OF DECEASED	
29. NAME OF DECEASED		30. NAME OF DECEASED	
31. NAME OF DECEASED		32. NAME OF DECEASED	
33. NAME OF DECEASED		34. NAME OF DECEASED	
35. NAME OF DECEASED		36. NAME OF DECEASED	
37. NAME OF DECEASED		38. NAME OF DECEASED	
39. NAME OF DECEASED		40. NAME OF DECEASED	
41. NAME OF DECEASED		42. NAME OF DECEASED	
43. NAME OF DECEASED		44. NAME OF DECEASED	
45. NAME OF DECEASED		46. NAME OF DECEASED	
47. NAME OF DECEASED		48. NAME OF DECEASED	
49. NAME OF DECEASED		50. NAME OF DECEASED	
51. NAME OF DECEASED		52. NAME OF DECEASED	
53. NAME OF DECEASED		54. NAME OF DECEASED	
55. NAME OF DECEASED		56. NAME OF DECEASED	
57. NAME OF DECEASED		58. NAME OF DECEASED	
59. NAME OF DECEASED		60. NAME OF DECEASED	
61. NAME OF DECEASED		62. NAME OF DECEASED	
63. NAME OF DECEASED		64. NAME OF DECEASED	
65. NAME OF DECEASED		66. NAME OF DECEASED	
67. NAME OF DECEASED		68. NAME OF DECEASED	
69. NAME OF DECEASED		70. NAME OF DECEASED	
71. NAME OF DECEASED		72. NAME OF DECEASED	
73. NAME OF DECEASED		74. NAME OF DECEASED	
75. NAME OF DECEASED		76. NAME OF DECEASED	
77. NAME OF DECEASED		78. NAME OF DECEASED	
79. NAME OF DECEASED		80. NAME OF DECEASED	
81. NAME OF DECEASED		82. NAME OF DECEASED	
83. NAME OF DECEASED		84. NAME OF DECEASED	
85. NAME OF DECEASED		86. NAME OF DECEASED	
87. NAME OF DECEASED		88. NAME OF DECEASED	
89. NAME OF DECEASED		90. NAME OF DECEASED	
91. NAME OF DECEASED		92. NAME OF DECEASED	
93. NAME OF DECEASED		94. NAME OF DECEASED	
95. NAME OF DECEASED		96. NAME OF DECEASED	
97. NAME OF DECEASED		98. NAME OF DECEASED	
99. NAME OF DECEASED		100. NAME OF DECEASED	

BUREAU V. S.

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

12129

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>				47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2106 N. St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christine M. Melvin</u>				4. DATE OF DEATH Month Day Year <u>11 6 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/21/03</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>Scranton, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank Raymond (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Griffiths (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Brother- Mr. Frank Raymond</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal Insufficiency (Addisonian Crisis)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis of Adrenal Glands</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002x Pulmonary Tuberculosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3 Nov</u> , 19 <u>57</u> , to <u>6 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 Nov</u> , 19 <u>57</u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5029 Bethesda Ave 7 Nov 57</u> <u>Beth. Md</u>			
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Abington Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lackawanna Co. Penna/</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>DATE 11-8-57</u>				24b. REGISTRAR'S SIGNATURE <u>T Benair M. Thompson</u>			

RECEIVED

12130 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Front Royal 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First George Middle Francis Last MENTZ		4. DATE OF DEATH Month November Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 April 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. MENTZ		14. MOTHER'S MAIDEN NAME Florence L. MILLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1918 to 1947		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Wife, Erica P. MENTZ		Address (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 162X			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-28 19 57 , to 11-29 19 57 , that I last saw the deceased alive on 11-29 19 57 , and that death occurred at 6:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 11-29-57			
ACTUAL SIGNATURE Bruce H. Rice		M.D. U.S. Naval Hospital, Bethesda, Md. 11-29-57	
PHYSICIAN'S NAME (Type) Bruce H. Rice, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-3-57	22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 3072 M St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 11-29-57	24b. REGISTRAR'S SIGNATURE Mary E. Carroll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		8 YEARS		MARRIED		1945		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
HEART DISEASE		NATURAL		12/15/45		BALTIMORE, MD.		J. H. HARRIS		J. H. HARRIS	

RECEIVED
BUREAU V. 2
 DEC 4 1957

45000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

CERTIFICATE OF DEATH

12123

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 5518 - 4th Street N.W.			
3. NAME OF DECEASED (Type or print) First FANNIE Middle - Last MILLER				4. DATE OF DEATH Month November Day 16, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1892		9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Abraham				14. MOTHER'S MAIDEN NAME -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-36-4170		17. INFORMANT Arthur Miller 5525 Chillum Pl., N.E. D.C. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous primary site perineal DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to November 1957 , that I last saw the deceased alive on Nov 16 , 1957, and that death occurred at 9 a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8641 Colesville Rd., SSpg, Md. DATE SIGNED							
ACTUAL SIGNATURE Blaine H. Fig				M.D. 8641 Colesville Rd., SSpg, Md.			
PHYSICIAN'S NAME (Type) Dr. Blaine H. Fig							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/1957		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Howard Home ADDRESS 4217 9th Street N.W. DC				24a. REC'D BY REGISTRAR 11-20-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

NOV 21 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12132

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b .10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 9333 Wellington Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ruth Middle Virginia Last MILLMAN				4. DATE OF DEATH Month November Day 30 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 March 1922	
9. AGE (In years last birthday) 35		IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min. 35		IF UNDER 24 HRS. Months 35 Days 35 Hours 35 Min. 35			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Albert CRANDALL				14. MOTHER'S MAIDEN NAME Annetta BONDS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Chester John MILLMAN (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Infarction, myocardium, acute DUE TO thrombosis, rt. coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 260x Diabetes mellitus DUE TO (c) 260x Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington, Virginia				20g. (County) Arlington		20h. (State) Virginia	
21. I certify that I attended the deceased from 20 Nov. 19 57 , to 30 Nov. 19 57 , that I last saw the deceased alive on 29 November 19 57 , and that death occurred at 5:20A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.B. Ingram				DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 11-30-57			
PHYSICIAN'S NAME (Type) W.B. INGRAM, CDR, MC, USN				ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers				24a. REC'D BY REGISTRAR 11-30-57			
24b. REGISTRAR'S SIGNATURE May E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

REC 4 1957

RECEIVED

1

12133

12125

12133

CERTIFICATE OF DEATH

Reg. Dist. No. 217

12125

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 30 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS 120 Commerce Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Edward Middle — Last Mills				4. DATE OF DEATH Month November Day 1 Year 19 57				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/09		
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Formerly with Liquor Control Board				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U. S. A.		
13. FATHER'S NAME Edward Mills				14. MOTHER'S MAIDEN NAME Mary C. Dale				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 214-16-7698		17. INFORMANT Dorothy Kosian		Address Rockville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Myocardial failure DUE TO (b) Gastrointestinal bleeding DUE TO (c) Cirrhosis of liver, with jaundice PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH few hours Several days Several months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Oct. 29 , 19 57 , to Nov. 1 , 19 57 , that I last saw the deceased alive on Nov. 1 , 19 57 , and that death occurred at 8:42 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave. DATE SIGNED Nov. 2, 1957 ACTUAL SIGNATURE W. A. Linthicum M.D. W. A. Linthicum, M.D. PHYSICIAN'S NAME (Type) W. A. Linthicum, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 4/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md		
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Barber				ADDRESS 1119		24a. REC'D BY REGISTRAR DATE 11-6-57		
				24b. REGISTRAR'S SIGNATURE Estimote B. Lander				

CERTIFICATE OF DEATH

NAME OF DECEASED Dorothy Louise		DATE OF BIRTH 1911		PLACE OF BIRTH Rockville, Md.	
SEX Female		MARRIAGE Married		DATE OF MARRIAGE 1930	
EDUCATION High School		OCCUPATION Homemaker		DATE OF DEATH November 1, 1957	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Rockville, Md.	
SIGNATURE OF PHYSICIAN J. A. Smith		SIGNATURE OF DECEASED Dorothy Louise		SIGNATURE OF WITNESSES J. A. Smith, M.D.	
DATE OF SIGNATURE November 1, 1957		DATE OF SIGNATURE November 1, 1957		DATE OF SIGNATURE November 1, 1957	

BUREAU V. 2

NOV 13 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 11-29-57 et
12134 CERTIFICATE OF DEATH

12126

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bertshire/ Berkshire 16x2.2	
3. NAME OF DECEASED (Type or print) First Charles Middle (nmn) Last MITCHELL		4. DATE OF DEATH Month November Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 June 1891
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John MITCHELL		14. MOTHER'S MAIDEN NAME Mary HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 11-6-17 to 7-26-19		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Grace Belle MITCHELL (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. about 14 days DUE TO Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Nov. 19 57 , to 6 Nov. 19 57 , that I last saw the deceased alive on 6 Nov. 19 57 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-7-57			
ACTUAL SIGNATURE T.S. Dunn Jr		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-9-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS Chambers, 517 11th Street, N.E. Washington, D.C.	
24a. REC'D BY REGISTRAR 11-6-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65	SEX Male	RACE White
DATE OF DEATH November 18, 1957		PLACE OF DEATH Home	CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		
SIGNATURE OF WITNESSES J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		

NAME OF DECEASED JAMES H. HARRIS		AGE 65	SEX Male	RACE White
DATE OF DEATH November 18, 1957		PLACE OF DEATH Home	CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		
SIGNATURE OF WITNESSES J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 11, File 3222, 11/22/57, for

12135

CERTIFICATE OF DEATH

12127

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>M</u> Last <u>Mueller</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 9 - 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>18</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>6</u> Days <u>9</u> Hours <u>18</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>DAUGHTER</u> Address <u>MRS MARY CADY - 11101 DEWEY RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Infarction, right post-central gyrus of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral arteriosclerosis, severe</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive + arteriosclerotic cardiovascular disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. DECEASED WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3 July</u> , 1957, to <u>Nov 16</u> , 1957, that I last saw the deceased alive on <u>Nov 15</u> , 1957, and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herace W. Bernton</u> M.D.				ADDRESS (Street, city or town, state) <u>10511 Summit Ave., Kensington, Md.</u> DATE SIGNED <u>11-16-57</u>			
PHYSICIAN'S NAME (Type) <u>Herace W. Bernton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal - Burial</u>		22b. DATE THEREOF <u>11-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Ewing</u>				24a. REC'D BY REGISTRAR <u>809 King St Va</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

2

74

1

CERTIFICATE OF DEATH

File No. 10

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. RACE
9. RELIGION
10. EDUCATION
11. SOCIAL SECURITY NUMBER
12. DATE OF DEATH
13. PLACE OF DEATH
14. CAUSE OF DEATH
15. MANNER OF DEATH
16. SIGNATURE OF PHYSICIAN
17. SIGNATURE OF REGISTRAR
18. SIGNATURE OF WITNESS

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12020 CERTIFICATE OF DEATH

12128

223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>9 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>1209 Lincoln Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Julia</i> First <i>RICHARDSON</i> Middle <i>NEUFFER</i> Last		4. DATE OF DEATH Month <i>Nov</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3, 1869</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Music Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Danishon N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. of America</i>	
13. FATHER'S NAME <i>Wilson James Richardson</i>		14. MOTHER'S MAIDEN NAME <i>Sauria Kennon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>267-14-4205</i>	
17. INFORMANT <i>Julia Richardson Neuffer</i> Address <i>Same</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic pneumonia right lung</i> 493X DUE TO <i>Cardiac and Respiratory Failure.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senility</i> DUE TO (c) <i>Senility</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 wks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1954, to <i>Nov. 12</i> , 1957, that I last saw the deceased alive on <i>Nov 19</i> , 1957, and that death occurred at <i>3:10 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring Md.</i>	
DATE SIGNED <i>Nov 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>F. M. Jones</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 21, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>GEORGE WASHINGTON</i>		22d. LOCATION (City, town, or county) (State) <i>Ed. ROBERT WHITEVILLE Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip E. Jones</i> ADDRESS <i>254 Carroll St. NW.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 22 1957</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Baltimore, Md.</i>		5. DATE OF BIRTH <i>Jan 15, 1912</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. DATE OF DEATH <i>Nov 15, 1957</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF BURIAL <i>St. Mary's Cemetery</i>	
16. NAME OF CLERK OF COURT <i>John Doe</i>		17. NAME OF CLERK OF COURT <i>John Doe</i>		18. NAME OF CLERK OF COURT <i>John Doe</i>	
19. NAME OF CLERK OF COURT <i>John Doe</i>		20. NAME OF CLERK OF COURT <i>John Doe</i>		21. NAME OF CLERK OF COURT <i>John Doe</i>	
22. NAME OF CLERK OF COURT <i>John Doe</i>		23. NAME OF CLERK OF COURT <i>John Doe</i>		24. NAME OF CLERK OF COURT <i>John Doe</i>	
25. NAME OF CLERK OF COURT <i>John Doe</i>		26. NAME OF CLERK OF COURT <i>John Doe</i>		27. NAME OF CLERK OF COURT <i>John Doe</i>	
28. NAME OF CLERK OF COURT <i>John Doe</i>		29. NAME OF CLERK OF COURT <i>John Doe</i>		30. NAME OF CLERK OF COURT <i>John Doe</i>	
31. NAME OF CLERK OF COURT <i>John Doe</i>		32. NAME OF CLERK OF COURT <i>John Doe</i>		33. NAME OF CLERK OF COURT <i>John Doe</i>	
34. NAME OF CLERK OF COURT <i>John Doe</i>		35. NAME OF CLERK OF COURT <i>John Doe</i>		36. NAME OF CLERK OF COURT <i>John Doe</i>	
37. NAME OF CLERK OF COURT <i>John Doe</i>		38. NAME OF CLERK OF COURT <i>John Doe</i>		39. NAME OF CLERK OF COURT <i>John Doe</i>	
40. NAME OF CLERK OF COURT <i>John Doe</i>		41. NAME OF CLERK OF COURT <i>John Doe</i>		42. NAME OF CLERK OF COURT <i>John Doe</i>	
43. NAME OF CLERK OF COURT <i>John Doe</i>		44. NAME OF CLERK OF COURT <i>John Doe</i>		45. NAME OF CLERK OF COURT <i>John Doe</i>	
46. NAME OF CLERK OF COURT <i>John Doe</i>		47. NAME OF CLERK OF COURT <i>John Doe</i>		48. NAME OF CLERK OF COURT <i>John Doe</i>	
49. NAME OF CLERK OF COURT <i>John Doe</i>		50. NAME OF CLERK OF COURT <i>John Doe</i>		51. NAME OF CLERK OF COURT <i>John Doe</i>	
52. NAME OF CLERK OF COURT <i>John Doe</i>		53. NAME OF CLERK OF COURT <i>John Doe</i>		54. NAME OF CLERK OF COURT <i>John Doe</i>	
55. NAME OF CLERK OF COURT <i>John Doe</i>		56. NAME OF CLERK OF COURT <i>John Doe</i>		57. NAME OF CLERK OF COURT <i>John Doe</i>	
58. NAME OF CLERK OF COURT <i>John Doe</i>		59. NAME OF CLERK OF COURT <i>John Doe</i>		60. NAME OF CLERK OF COURT <i>John Doe</i>	
61. NAME OF CLERK OF COURT <i>John Doe</i>		62. NAME OF CLERK OF COURT <i>John Doe</i>		63. NAME OF CLERK OF COURT <i>John Doe</i>	
64. NAME OF CLERK OF COURT <i>John Doe</i>		65. NAME OF CLERK OF COURT <i>John Doe</i>		66. NAME OF CLERK OF COURT <i>John Doe</i>	
67. NAME OF CLERK OF COURT <i>John Doe</i>		68. NAME OF CLERK OF COURT <i>John Doe</i>		69. NAME OF CLERK OF COURT <i>John Doe</i>	
70. NAME OF CLERK OF COURT <i>John Doe</i>		71. NAME OF CLERK OF COURT <i>John Doe</i>		72. NAME OF CLERK OF COURT <i>John Doe</i>	
73. NAME OF CLERK OF COURT <i>John Doe</i>		74. NAME OF CLERK OF COURT <i>John Doe</i>		75. NAME OF CLERK OF COURT <i>John Doe</i>	
76. NAME OF CLERK OF COURT <i>John Doe</i>		77. NAME OF CLERK OF COURT <i>John Doe</i>		78. NAME OF CLERK OF COURT <i>John Doe</i>	
79. NAME OF CLERK OF COURT <i>John Doe</i>		80. NAME OF CLERK OF COURT <i>John Doe</i>		81. NAME OF CLERK OF COURT <i>John Doe</i>	
82. NAME OF CLERK OF COURT <i>John Doe</i>		83. NAME OF CLERK OF COURT <i>John Doe</i>		84. NAME OF CLERK OF COURT <i>John Doe</i>	
85. NAME OF CLERK OF COURT <i>John Doe</i>		86. NAME OF CLERK OF COURT <i>John Doe</i>		87. NAME OF CLERK OF COURT <i>John Doe</i>	
88. NAME OF CLERK OF COURT <i>John Doe</i>		89. NAME OF CLERK OF COURT <i>John Doe</i>		90. NAME OF CLERK OF COURT <i>John Doe</i>	
91. NAME OF CLERK OF COURT <i>John Doe</i>		92. NAME OF CLERK OF COURT <i>John Doe</i>		93. NAME OF CLERK OF COURT <i>John Doe</i>	
94. NAME OF CLERK OF COURT <i>John Doe</i>		95. NAME OF CLERK OF COURT <i>John Doe</i>		96. NAME OF CLERK OF COURT <i>John Doe</i>	
97. NAME OF CLERK OF COURT <i>John Doe</i>		98. NAME OF CLERK OF COURT <i>John Doe</i>		99. NAME OF CLERK OF COURT <i>John Doe</i>	
100. NAME OF CLERK OF COURT <i>John Doe</i>		101. NAME OF CLERK OF COURT <i>John Doe</i>		102. NAME OF CLERK OF COURT <i>John Doe</i>	

RECEIVED
NOV 25 1957
BUREAU V. S.

12136 CERTIFICATE OF DEATH

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Georgia</u> b. COUNTY <u>Atlanta</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Concordville Mar Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>3200 Brookway Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>JO</u> Middle <u>FRANKLIN</u> Last <u>NEVILLE</u>				DATE OF DEATH <u>Nov 24 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 6 1913</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mgr representative furniture</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>ATLANTA, GA.</u>	
13. FATHER'S NAME <u>J. FRANKLIN NEVILLE</u>				14. MOTHER'S MAIDEN NAME <u>SEABORN OSBORNE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>WW2 4 yrs</u>				16. SOCIAL SECURITY NO. <u>W 4445</u>			
17. INFORMANT <u>MR. MR. WM. A. SPIKER</u>				Address <u>3200 Brookway Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 min</u> (c) <u>10 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>57</u> p. m. <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Atlanta</u>				20g. (County) <u>Atlanta</u>		20h. (State) <u>Georgia</u>	
21. I certify that I attended the deceased from <u>11/24</u> , 19 <u>57</u> , to <u>11/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/24/57</u> , 19 <u>57</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS (Street, city or town, state) <u>5009 Seaboard Rd Wash 16 DC</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Pumphrey</u>				DATE SIGNED <u>Nov. 24, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-transit</u>		<u>11-25-57</u>		<u>Atlanta</u>		<u>Atlanta, Georgia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

NOV 29 1957

RECEIVED

12137

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b Home			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 Colesville Road-Marilea Nursing				d. STREET ADDRESS 3817 Decatur Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ELMER NORRIS				4. DATE OF DEATH Month Day Year November 23 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1892	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min. 9 14	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Norris				14. MOTHER'S MAIDEN NAME Ida Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-2513		17. INFORMANT Address Daisy H. Norris-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 21, 19 57 to death, 19 57 , that I last saw the deceased alive on Nov. 21, 19 57 and that death occurred at 12:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Belden R. Reap M.D.				ADDRESS (Street, city or town, state) 11502 Grandview Ave. Silver Spring, Md.		DATE SIGNED 11/23/57	
PHYSICIAN'S NAME (Type) BELDEN R. REAP							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/1957	22c. NAME OF CEMETERY OR CREMATORY Rockville Cem. Assn.		22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR NOV 26 1957		24b. REGISTRAR'S SIGNATURE Frances P. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12037

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Thomas Street				d. STREET ADDRESS 18 Thomas St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALICE WINDSOR NOURSE				4. DATE OF DEATH Nov. 10, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 9		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME James S. Windsor				14. MOTHER'S MAIDEN NAME Sarah Darby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Harrison England-	
				Address 8 Thomas Street Rockville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right hemiplegia DUE TO (c) Arteriosclerotic cerebral vascular disease						INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1947 , to 10 Nov, 1957 , that I last saw the deceased alive on 9 Nov, 1957 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Fawcett				ADDRESS (Street, city or town, state) Dorsonville, P.O. Box D, Md.			
PHYSICIAN'S NAME (Type) John Fawcett				DATE SIGNED 11/10/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Darnestown Church Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE Nov 13 57			
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1990-1991

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BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **213**

12021

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
c. LENGTH OF STAY IN 1b 3 yrs		d. STREET ADDRESS 11 Pine Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Pine Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julius Ochs		4. DATE OF DEATH Month Nov. Day 12, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1905
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karl Ochs		14. MOTHER'S MAIDEN NAME Annie E. Carrigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 16	
17. INFORMANT Karl W. Ochs, 5415 Conn. Ave. N.W. Wash. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Walter, 254 Carroll St NW D.C.		24a. REC'D BY REGISTRAR DATE 11/14/57	
24b. REGISTRAR'S SIGNATURE J. Wilson Redd			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

12022

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b One Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2	
4. DATE OF DEATH First Lucia Middle E Last O'Donnell		4. DATE OF DEATH Month N Day ovember Year 14 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Griffith		14. MOTHER'S MAIDEN NAME Lillian A. Donedri	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT William F. O'Donnell		Address 2104 Amherst Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416x Congestive Heart Failure DUE TO (b) Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26, 1953 , to Nov 13, 1957 , that I last saw the deceased alive on Nov 13, 1957 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wayne Chickfield MD November 14, 1957 PHYSICIAN'S NAME (Type) WAYNE CHICKFIELD MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Levers Sons Co		24a. REC'D BY REGISTRAR 3605-14 NOV 15 1957	
24b. REGISTRAR'S SIGNATURE J. Wilson Dodd		DATE Wash. DC	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12134

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 15 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Clinton Last Offutt		4. DATE OF DEATH Month November Day 6 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 March 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professional Bondsman		10b. KIND OF BUSINESS OR INDUSTRY Bonding	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Offutt		14. MOTHER'S MAIDEN NAME Mary Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-32-7344	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ATHEROSCLEROSIS (c) Carcinoma Prostate		INTERVAL BETWEEN ONSET AND DEATH 10 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-6 10:30 AM 19 57 , to 10:45 AM 11-6 19 57 , that I last saw the deceased alive on 10:45 AM 11-6 19 57 , and that death occurred at 10:45 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/6/57 ACTUAL SIGNATURE William J. Pieper M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) William J. Pieper, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/9/57	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey - Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 11-8-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		11/12/57	
AGE		35 yrs.	
SEX		Male	
RACE		White	
BIRTH DATE		10/12/22	
BIRTH PLACE		Baltimore, Md.	
MARRIAGE		Married	
SPOUSE		Mary H. Harris	
OCCUPATION		Salesman	
EDUCATION		High School	
RELIGION		Roman Catholic	
CAUSE OF DEATH		Heart Disease	
PLACE OF DEATH		Home	
SIGNATURE OF PHYSICIAN		[Signature]	
DATE OF SIGNATURE		11/12/57	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF SIGNATURE		11/12/57	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12139

CERTIFICATE OF DEATH

12135

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		d. STREET ADDRESS 3615 KANAWHA ST. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First INGWALD Middle C Last OLSEN		4. DATE OF DEATH Month 11 Day 11 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THEODORE OLSEN		14. MOTHER'S MAIDEN NAME MEENA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT CARL I. OLSEN		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of Right Colon - abscess Right thigh			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19____, to Nov 11, 1957 , that I last saw the deceased alive on Nov 11, 1957 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James H Sully		DATE SIGNED 1835 Eye St N.W. Wash 6	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 11/15/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR NOV 14 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED M. J. JONES		MARRIAGE M. J. JONES	
AGE 45		SEX M	
DATE OF BIRTH JAN 15 1912		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease	
DATE OF DEATH NOV 14 1957		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED M. J. JONES		SIGNATURE OF WITNESS J. J. JONES	
DATE OF SIGNATURE NOV 14 1957		DATE OF SIGNATURE NOV 14 1957	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF CLERK J. J. JONES	
DATE OF SIGNATURE NOV 14 1957		DATE OF SIGNATURE NOV 14 1957	
SIGNATURE OF DECEASED M. J. JONES		SIGNATURE OF WITNESS J. J. JONES	
DATE OF SIGNATURE NOV 14 1957		DATE OF SIGNATURE NOV 14 1957	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF CLERK J. J. JONES	
DATE OF SIGNATURE NOV 14 1957		DATE OF SIGNATURE NOV 14 1957	

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NOV 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12023

CERTIFICATE OF DEATH

12136
773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN HOME <u>43 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San Hosp</u>			d. STREET ADDRESS <u>17011 Sycamore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Louise</u> Last <u>Partin</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1957</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>17/25 Jan / 1908</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker - own home</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Morris Smith</u>		
14. MOTHER'S MAIDEN NAME <u>Emmgi Anderson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Hosp Records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure - Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>several months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u> <u>Acute bronchopneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10-15-</u> , 1957, to <u>11-26-</u> , 1957, that I last saw the deceased alive on <u>11-25-</u> , 1957, and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Norman C. Shoemaker</u>			ADDRESS (Street, city or town, state) <u>8005 Woodbury Dr., Silver Spring, Md.</u>		
PHYSICIAN'S NAME (Type) <u>Norman C. Shoemaker</u>			DATE SIGNED <u>11/27/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>		22e. (State) <u>MD</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD</u>		24a. REC'D BY REGISTRAR <u>NOV 20 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Nelson Addy</u>					

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

PLACE OF DEATH		MANNER OF DEATH	
HOSPITAL		NATURAL	
HOME		SUICIDE	
OTHER		OTHER	
DATE OF DEATH		TIME OF DEATH	
1957		10:00	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE		1957	
AGE		SEX	
30		F	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		MARITAL STATUS	
Nurse		Married	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Heart Disease	
MEDICAL HISTORY		PATHOLOGICAL FINDINGS	
None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		TIME	
1957		10:00	

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NOV 29 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12024 CERTIFICATE OF DEATH

Reg. Dist. No.

12137
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Jakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7115 Sycamore Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>PEPPER</u> Last <u>PEPPER</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1892</u>		9. AGE (In years lost birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Pepper</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>102-03-3599</u>		17. INFORMANT Address <u>Mrs. Marie Pepper, (same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11-19-57</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Overweight</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov-16</u> , 19 <u>57</u> , to <u>Nov-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov-16</u> , 19 <u>57</u> , and that death occurred at <u>11 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.				ADDRESS (Street, city or town, state) <u>9601 Colesville Rd. Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				DATE SIGNED <u>11-19-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>REGS RD. HUNTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Ave NW D.C.</u>				24. REC'D BY REGISTRAR <u>NOV 22 1957</u> 25. REGISTRAR'S SIGNATURE <u>William D. Dold</u>			

• **Figure 10.10** illustrates the relationship between the number of units produced and the total cost of production. The total cost curve is U-shaped, reflecting the U-shaped average total cost curve. The total cost curve is the sum of the total variable cost curve and the total fixed cost curve. The total fixed cost curve is a straight line starting from the origin and increasing linearly with the number of units produced. The total variable cost curve is U-shaped, reflecting the U-shaped average variable cost curve. The total cost curve is U-shaped, reflecting the U-shaped average total cost curve.

BUREAU V. S.

1957 25 AGI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

12140 CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4930 Belt Rd. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Viola</u> Last <u>Petrola</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1885</u> 71 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alexander Shaper</u>				14. MOTHER'S MAIDEN NAME <u>Croft, Virginia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Harry Petrola, 4920 Belt Rd. DC</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Thrombosis</u> (b) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Thrombosis</u> (c) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Carcinoma Breast</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August</u> 19 <u>57</u> to <u>Nov 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-17-57</u> , 19 <u>57</u> , and that death occurred at <u>10:48 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington</u> DATE SIGNED <u>11-17-57</u> ACTUAL SIGNATURE <u>P.P. Andrews</u> M.D. <u>Washington</u> PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS M.D. WASHINGTON 1605 11-17-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 20, 1957</u>		<u>Cedar Hill</u>		<u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>1400 Chapin St. Wash DC</u>				24a. REC'D BY REGISTRAR <u>Nov 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jessie Thompson</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 19

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. TEETH		20. NAILS		21. FINGERPRINTS		22. SIGNATURE		23. DATE		24. TIME		25. PLACE		26. CAUSE		27. MANNER		28. MEDICAL HISTORY		29. PRESENT ILLNESS		30. TREATMENT		31. RESULTS		32. COMMENTS		33. SIGNATURE		34. DATE		35. TIME		36. PLACE		37. CAUSE		38. MANNER		39. MEDICAL HISTORY		40. PRESENT ILLNESS		41. TREATMENT		42. RESULTS		43. COMMENTS		44. SIGNATURE		45. DATE		46. TIME		47. PLACE		48. CAUSE		49. MANNER		50. MEDICAL HISTORY		51. PRESENT ILLNESS		52. TREATMENT		53. RESULTS		54. COMMENTS		55. SIGNATURE		56. DATE		57. TIME		58. PLACE		59. CAUSE		60. MANNER		61. MEDICAL HISTORY		62. PRESENT ILLNESS		63. TREATMENT		64. RESULTS		65. COMMENTS		66. SIGNATURE		67. DATE		68. TIME		69. PLACE		70. CAUSE		71. MANNER		72. MEDICAL HISTORY		73. PRESENT ILLNESS		74. TREATMENT		75. RESULTS		76. COMMENTS		77. SIGNATURE		78. DATE		79. TIME		80. PLACE		81. CAUSE		82. MANNER		83. MEDICAL HISTORY		84. PRESENT ILLNESS		85. TREATMENT		86. RESULTS		87. COMMENTS		88. SIGNATURE		89. DATE		90. TIME		91. PLACE		92. CAUSE		93. MANNER		94. MEDICAL HISTORY		95. PRESENT ILLNESS		96. TREATMENT		97. RESULTS		98. COMMENTS		99. SIGNATURE		100. DATE		101. TIME		102. PLACE		103. CAUSE		104. MANNER		105. MEDICAL HISTORY		106. PRESENT ILLNESS		107. TREATMENT		108. RESULTS		109. COMMENTS		110. SIGNATURE		111. DATE		112. TIME		113. PLACE		114. CAUSE		115. MANNER		116. MEDICAL HISTORY		117. PRESENT ILLNESS		118. TREATMENT		119. RESULTS		120. COMMENTS		121. SIGNATURE		122. DATE		123. TIME		124. PLACE		125. CAUSE		126. MANNER		127. MEDICAL HISTORY		128. PRESENT ILLNESS		129. TREATMENT		130. RESULTS		131. COMMENTS		132. SIGNATURE		133. DATE		134. TIME		135. PLACE		136. CAUSE		137. MANNER		138. MEDICAL HISTORY		139. PRESENT ILLNESS		140. TREATMENT		141. RESULTS		142. COMMENTS		143. SIGNATURE		144. DATE		145. TIME		146. PLACE		147. CAUSE		148. MANNER		149. MEDICAL HISTORY		150. PRESENT ILLNESS		151. TREATMENT		152. RESULTS		153. COMMENTS		154. SIGNATURE		155. DATE		156. TIME		157. PLACE		158. CAUSE		159. MANNER		160. MEDICAL HISTORY		161. PRESENT ILLNESS		162. TREATMENT		163. RESULTS		164. COMMENTS		165. SIGNATURE		166. DATE		167. TIME		168. PLACE		169. CAUSE		170. MANNER		171. MEDICAL HISTORY		172. PRESENT ILLNESS		173. TREATMENT		174. RESULTS		175. COMMENTS		176. SIGNATURE		177. DATE		178. TIME		179. PLACE		180. CAUSE		181. MANNER		182. MEDICAL HISTORY		183. PRESENT ILLNESS		184. TREATMENT		185. RESULTS		186. COMMENTS		187. SIGNATURE		188. DATE		189. TIME		190. PLACE		191. CAUSE		192. MANNER		193. MEDICAL HISTORY		194. PRESENT ILLNESS		195. TREATMENT		196. RESULTS		197. COMMENTS		198. SIGNATURE		199. DATE		200. TIME		201. PLACE		202. CAUSE		203. MANNER		204. MEDICAL HISTORY		205. PRESENT ILLNESS		206. TREATMENT		207. RESULTS		208. COMMENTS		209. SIGNATURE		210. DATE		211. TIME		212. PLACE		213. CAUSE		214. MANNER		215. MEDICAL HISTORY		216. PRESENT ILLNESS		217. TREATMENT		218. RESULTS		219. COMMENTS		220. SIGNATURE		221. DATE		222. TIME		223. PLACE		224. CAUSE		225. MANNER		226. MEDICAL HISTORY		227. PRESENT ILLNESS		228. TREATMENT		229. RESULTS		230. COMMENTS		231. SIGNATURE		232. DATE		233. TIME		234. PLACE		235. CAUSE		236. MANNER		237. MEDICAL HISTORY		238. PRESENT ILLNESS		239. TREATMENT		240. RESULTS		241. COMMENTS		242. SIGNATURE		243. DATE		244. TIME		245. PLACE		246. CAUSE		247. MANNER		248. MEDICAL HISTORY		249. PRESENT ILLNESS		250. TREATMENT		251. RESULTS		252. COMMENTS		253. SIGNATURE		254. DATE		255. TIME		256. PLACE		257. CAUSE		258. MANNER		259. MEDICAL HISTORY		260. PRESENT ILLNESS		261. TREATMENT		262. RESULTS		263. COMMENTS		264. SIGNATURE		265. DATE		266. TIME		267. PLACE		268. CAUSE		269. MANNER		270. MEDICAL HISTORY		271. PRESENT ILLNESS		272. TREATMENT		273. RESULTS		274. COMMENTS		275. SIGNATURE		276. DATE		277. TIME		278. PLACE		279. CAUSE		280. MANNER		281. MEDICAL HISTORY		282. PRESENT ILLNESS		283. TREATMENT		284. RESULTS		285. COMMENTS		286. SIGNATURE		287. DATE		288. TIME		289. PLACE		290. CAUSE		291. MANNER		292. MEDICAL HISTORY		293. PRESENT ILLNESS		294. TREATMENT		295. RESULTS		296. COMMENTS		297. SIGNATURE		298. DATE		299. TIME		300. PLACE		301. CAUSE		302. MANNER		303. MEDICAL HISTORY		304. PRESENT ILLNESS		305. TREATMENT		306. RESULTS		307. COMMENTS		308. SIGNATURE		309. DATE		310. TIME		311. PLACE		312. CAUSE		313. MANNER		314. MEDICAL HISTORY		315. PRESENT ILLNESS		316. TREATMENT		317. RESULTS		318. COMMENTS		319. SIGNATURE		320. DATE		321. TIME		322. PLACE		323. CAUSE		324. MANNER		325. MEDICAL HISTORY		326. PRESENT ILLNESS		327. TREATMENT		328. RESULTS		329. COMMENTS		330. SIGNATURE		331. DATE		332. TIME		333. PLACE		334. CAUSE		335. MANNER		336. MEDICAL HISTORY		337. PRESENT ILLNESS		338. TREATMENT		339. RESULTS		340. COMMENTS		341. SIGNATURE		342. DATE		343. TIME		344. PLACE		345. CAUSE		346. MANNER		347. MEDICAL HISTORY		348. PRESENT ILLNESS		349. TREATMENT		350. RESULTS		351. COMMENTS		352. SIGNATURE		353. DATE		354. TIME		355. PLACE		356. CAUSE		357. MANNER		358. MEDICAL HISTORY		359. PRESENT ILLNESS		360. TREATMENT		361. RESULTS		362. COMMENTS		363. SIGNATURE		364. DATE		365. TIME		366. PLACE		367. CAUSE		368. MANNER		369. MEDICAL HISTORY		370. PRESENT ILLNESS		371. TREATMENT		372. RESULTS		373. COMMENTS		374. SIGNATURE		375. DATE		376. TIME		377. PLACE		378. CAUSE		379. MANNER		380. MEDICAL HISTORY		381. PRESENT ILLNESS		382. TREATMENT		383. RESULTS		384. COMMENTS		385. SIGNATURE		386. DATE		387. TIME		388. PLACE		389. CAUSE		390. MANNER		391. MEDICAL HISTORY		392. PRESENT ILLNESS		393. TREATMENT		394. RESULTS		395. COMMENTS		396. SIGNATURE		397. DATE		398. TIME		399. PLACE		400. CAUSE		401. MANNER		402. MEDICAL HISTORY		403. PRESENT ILLNESS		404. TREATMENT		405. RESULTS		406. COMMENTS		407. SIGNATURE		408. DATE		409. TIME		410. PLACE		411. CAUSE		412. MANNER		413. MEDICAL HISTORY		414. PRESENT ILLNESS		415. TREATMENT		416. RESULTS		417. COMMENTS		418. SIGNATURE		419. DATE		420. TIME		421. PLACE		422. CAUSE		423. MANNER		424. MEDICAL HISTORY		425. PRESENT ILLNESS		426. TREATMENT		427. RESULTS		428. COMMENTS		429. SIGNATURE		430. DATE		431. TIME		432. PLACE		433. CAUSE		434. MANNER		435. MEDICAL HISTORY		436. PRESENT ILLNESS		437. TREATMENT		438. RESULTS		439. COMMENTS		440. SIGNATURE		441. DATE		442. TIME		443. PLACE		444. CAUSE		445. MANNER		446. MEDICAL HISTORY		447. PRESENT ILLNESS		448. TREATMENT		449. RESULTS		450. COMMENTS		451. SIGNATURE		452. DATE		453. TIME		454. PLACE		455. CAUSE		456. MANNER		457. MEDICAL HISTORY		458. PRESENT ILLNESS		459. TREATMENT		460. RESULTS		461. COMMENTS		462. SIGNATURE		463. DATE		464. TIME		465. PLACE		466. CAUSE		467. MANNER		468. MEDICAL HISTORY		469. PRESENT ILLNESS		470. TREATMENT		471. RESULTS		472. COMMENTS		473. SIGNATURE		474. DATE		475. TIME		476. PLACE		477. CAUSE		478. MANNER		479. MEDICAL HISTORY		480. PRESENT ILLNESS		481. TREATMENT		482. RESULTS		483. COMMENTS		484. SIGNATURE		485. DATE		486. TIME		487. PLACE		488. CAUSE		489. MANNER		490. MEDICAL HISTORY		491. PRESENT ILLNESS		492. TREATMENT		493. RESULTS		494. COMMENTS		495. SIGNATURE		496. DATE		497. TIME		498. PLACE		499. CAUSE		500. MANNER		501. MEDICAL HISTORY		502. PRESENT ILLNESS		503. TREATMENT		504. RESULTS		505. COMMENTS		506. SIGNATURE		507. DATE		508. TIME		509. PLACE		510. CAUSE		511. MANNER		512. MEDICAL HISTORY		513. PRESENT ILLNESS		514. TREATMENT		515. RESULTS		516. COMMENTS		517. SIGNATURE		518. DATE		519. TIME		520. PLACE		521. CAUSE		522. MANNER		523. MEDICAL HISTORY		524. PRESENT ILLNESS		525. TREATMENT		526. RESULTS		527. COMMENTS		528. SIGNATURE		529. DATE		530. TIME		531. PLACE		532. CAUSE		533. MANNER		534. MEDICAL HISTORY		535. PRESENT ILLNESS		536. TREATMENT		537. RESULTS		538. COMMENTS		539. SIGNATURE		540. DATE		541. TIME		542. PLACE		543. CAUSE		544. MANNER		545. MEDICAL HISTORY		546. PRESENT ILLNESS		547. TREATMENT		548. RESULTS		549. COMMENTS		550. SIGNATURE		551. DATE		552. TIME		553. PLACE		554. CAUSE		555. MANNER		556. MEDICAL HISTORY		557. PRESENT ILLNESS		558. TREATMENT		559. RESULTS		560. COMMENTS		561. SIGNATURE		562. DATE		563. TIME		564. PLACE		565. CAUSE		566. MANNER		567. MEDICAL HISTORY		568. PRESENT ILLNESS		569. TREATMENT		570. RESULTS		571. COMMENTS		572. SIGNATURE		573. DATE		574. TIME		575. PLACE		576. CAUSE		577. MANNER		578. MEDICAL HISTORY		579. PRESENT ILLNESS		580. TREATMENT		581. RESULTS		582. COMMENTS		583. SIGNATURE		584. DATE		585. TIME		586. PLACE		587. CAUSE		588. MANNER		589. MEDICAL HISTORY		590. PRESENT ILLNESS		591. TREATMENT		592. RESULTS		593. COMMENTS		594. SIGNATURE		595. DATE		596. TIME		597. PLACE		598. CAUSE		599. MANNER		600. MEDICAL HISTORY		601. PRESENT ILLNESS		602. TREATMENT		603. RESULTS		604. COMMENTS		605. SIGNATURE		606. DATE		607. TIME		608. PLACE		609. CAUSE		610. MANNER		611. MEDICAL HISTORY		612. PRESENT ILLNESS		613. TREATMENT		614. RESULTS		615. COMMENTS		616. SIGNATURE		617. DATE		618. TIME		619. PLACE		620. CAUSE		621. MANNER		622. MEDICAL HISTORY		623. PRESENT ILLNESS		624. TREATMENT		625. RESULTS		626. COMMENTS		627. SIGNATURE		628. DATE		629. TIME		630. PLACE		631. CAUSE		632. MANNER		633. MEDICAL HISTORY		634. PRESENT ILLNESS		635. TREATMENT		636. RESULTS		637. COMMENTS		638. SIGNATURE		639. DATE		640. TIME		641. PLACE		642. CAUSE		643. MANNER		644. MEDICAL HISTORY		645. PRESENT ILLNESS		646. TREATMENT		647. RESULTS		648. COMMENTS		649. SIGNATURE		650. DATE		651. TIME		652. PLACE		653. CAUSE		654. MANNER		655. MEDICAL HISTORY		656. PRESENT ILLNESS		657. TREATMENT		658. RESULTS		659. COMMENTS		660. SIGNATURE		661. DATE		662. TIME		663. PLACE		664. CAUSE		665. MANNER		666. MEDICAL HISTORY		667. PRESENT ILLNESS		668. TREATMENT		669. RESULTS		670. COMMENTS		671. SIGNATURE		672. DATE		673. TIME		674. PLACE		675. CAUSE		676. MANNER		677. MEDICAL HISTORY		678. PRESENT ILLNESS		679. TREATMENT		680. RESULTS		681. COMMENTS		682. SIGNATURE		683. DATE		684. TIME		685. PLACE		686. CAUSE		687. MANNER		688. MEDICAL HISTORY		689. PRESENT ILLNESS		690. TREATMENT		691. RESULTS		692. COMMENTS		693. SIGNATURE		694. DATE		695. TIME		696. PLACE		697. CAUSE		698. MANNER		699. MEDICAL HISTORY		700. PRESENT ILLNESS		701. TREATMENT		702. RESULTS		703. COMMENTS		704. SIGNATURE		705. DATE		706. TIME		707. PLACE		708. CAUSE		709. MANNER		710. MEDICAL HISTORY		711. PRESENT ILLNESS		712. TREATMENT		713. RESULTS		714. COMMENTS		715. SIGNATURE		716. DATE		717. TIME		718. PLACE		719. CAUSE		720. MANNER		721. MEDICAL HISTORY		722. PRESENT ILLNESS		723. TREATMENT		724. RESULTS		725. COMMENTS		726. SIGNATURE		727. DATE		728. TIME		729. PLACE		730. CAUSE		731. MANNER		732. MEDICAL HISTORY		733. PRESENT ILLNESS		734. TREATMENT		735. RESULTS		736. COMMENTS		737. SIGNATURE		738. DATE		739. TIME		740. PLACE		741. CAUSE		742. MANNER		743. MEDICAL HISTORY		744. PRESENT ILLNESS		745. TREATMENT		746. RESULTS		747. COMMENTS		748. SIGNATURE		749. DATE		750. TIME		751. PLACE		752. CAUSE		753. MANNER		754. MEDICAL HISTORY		755. PRESENT ILLNESS		756. TREATMENT		757. RESULTS		758. COMMENTS		759. SIGNATURE		760. DATE		761. TIME		762. PLACE		763. CAUSE		764. MANNER		765. MEDICAL HISTORY		766. PRESENT ILLNESS		767. TREATMENT		768. RESULTS		769. COMMENTS		770. SIGNATURE		771. DATE		772. TIME		773. PLACE		774. CAUSE		775. MANNER		776. MEDICAL HISTORY		777. PRESENT ILLNESS		778. TREATMENT		779. RESULTS		780. COMMENTS		781. SIGNATURE		782. DATE		783. TIME		784. PLACE		785. CAUSE		786. MANNER		787. MEDICAL HISTORY		788. PRESENT ILLNESS		789. TREATMENT		790. RESULTS		791. COMMENTS		792. SIGNATURE		793. DATE		794. TIME		795. PLACE		796. CAUSE		797. MANNER		798. MEDICAL HISTORY		799. PRESENT ILLNESS		800. TREATMENT		801. RESULTS		802. COMMENTS		803. SIGNATURE		804. DATE		805. TIME		806. PLACE		807. CAUSE		808. MANNER		809. MEDICAL HISTORY		810. PRESENT ILLNESS		811. TREATMENT		812. RESULTS		813. COMMENTS		814. SIGNATURE		815. DATE		816. TIME		817. PLACE		818. CAUSE		819. MANNER		820. MEDICAL HISTORY		821. PRESENT ILLNESS		822. TREATMENT		823. RESULTS			
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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

Reg. Dist. No. 219

Items 8 & 9, Film G-222 11/20/57.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 3 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 624 GIST AVENUE		e. STREET ADDRESS 631 ALLISON ST., N. W.	
3. NAME OF DECEASED (Type or print) JENNIE AMELIA PHILIPS		4. DATE OF DEATH Month NOVEMBER Day 8 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1873
9. AGE (In years last birthday) 83 8/4 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MINORSVILLE, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CALVIN B. PHILIPS		14. MOTHER'S MAIDEN NAME EMMA XXXXXXXXXX ETTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT BOYD C. PHILIPS, SR., 624 GIST AVE., SS., MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden			INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED Nov. 8, 1957	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REC'D BY REGISTRAR NOV 12 1957	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE Francis Potters	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 12 1957
BUREAU V. E.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12142

CERTIFICATE OF DEATH

Reg. Dist. No.

121404

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover Hills				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria				83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5408 Westover Hills home				d. STREET ADDRESS 22 Belfield Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Hill Ramage				4. DATE OF DEATH Month Day Year Nov. 6th 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12-03	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph C. Ramage				14. MOTHER'S MAIDEN NAME Blandine Blandford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Robt. Mc Cann 5408 Westover Hills, Albermarle St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the breast - 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, malnutrition - 441X							INTERVAL BETWEEN ONSET AND DEATH 3 yrs -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Nov , 19 57 , that I last saw the deceased alive on 11/6/57 , 19 57 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jackson T. Marland M.D. 1216-1681 N.W. 11/6/57 -							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8-1957		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery.		22d. LOCATION (City, town, or county) (State) Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Demaine				ADDRESS Alexandria Va.		24a. REC'D BY REGISTRAR DATE 11/12/57	
				24b. REGISTRAR'S SIGNATURE Frances Patter			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File this form

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REASON		DATE	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		BUILD	
TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		HEART		LUNGS		LIVER		SPLEEN	
KIDNEYS		STOMACH		INTESTINES		BLADDER		PROSTATE		UTERUS		VAGINA		TESTES	
THYROID		PARATHYROID		ADRENAL		PITUITARY		HYPOTHALAMUS		HYPOPHYSIS		EPIDIDYMOIDES		VASE DEFERENS	
SEMEN		URINE		FECES		SWEAT		TEARS		SALIVA		SPIT		VOICED	
SPEECH		HEARING		VISION		TASTE		SMELL		TOUCH		PAIN		TEMPERATURE	
MIND		MEMORY		REASON		IMAGINATION		EMOTION		WILL		FAITH		HOPE	
CHARACTER		TEMPERAMENT		MORALS		RELIGIOUS		POLITICAL		SOCIAL		FAMILY		PERSONAL	
HISTORY		SYMPTOMS		SIGNS		DIAGNOSIS		TREATMENT		PROGNOSIS		CAUSE		MANNER	
TIME		PLACE		CITY		STATE		COUNTRY		DATE		SIGNATURE		OFFICE	

BUREAU V. 2

NOV 13 1957

RECEIVED

12143

CERTIFICATE OF DEATH

Reg. Dist. No. 12141

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California				d. STREET ADDRESS Towncreek Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bruce Middle Lee Last REINHART				4. DATE OF DEATH Month November Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1957	9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Hours 5 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leonard J. REINHARD				14. MOTHER'S MAIDEN NAME Frances FLOY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Leonard J. Reinhart (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO 770.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Erythroblastosis Fetalis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 Minutes 50 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 17 Nov. , 19 57 , to 20 Nov. , 19 57 , that I last saw the deceased alive on 20 Nov. , 19 57 , and that death occurred at 4:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth W. Sell		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.					
DATE SIGNED 11-20-57							
PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-22-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey			ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 11-20-57	24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051334XV3

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		DR. JAMES H. HAYES	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10:00 AM		CONGRESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MAY 1945	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		PATHOLOGICAL DATA		LABORATORY DATA		RADIOLOGICAL DATA	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
JAMES EARL RAY		JAMES H. HAYES		JAMES H. HAYES		JAMES H. HAYES		JAMES H. HAYES		JAMES H. HAYES	

BUREAU V. R.

NOV 22 1967

RECEIVED

12144 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3926 Morrison Street, N. W.			
3. NAME OF DECEASED (Type or print) First Francis Middle David Last Rhodes				4. DATE OF DEATH Month November Day 17 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Rhodes				14. MOTHER'S MAIDEN NAME Frances Condon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE, (a) Coronary Artery Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Sigmoid Colon w/ metastases to liver, lung, & kidney.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 4 , 19 57 , to November 17 , 19 57 , that I last saw the deceased alive on November 17 , 19 57 , and that death occurred on 6:50 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/18/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Robert B. Couch M.D.							
PHYSICIAN'S NAME (Type) ROBERT B. COUCH, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 1-28-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12143

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>		c. LENGTH OF STAY IN TB <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colesville Rd.</u>			d. STREET ADDRESS <u>Colesville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edith Owen Rice</u>			4. DATE OF DEATH <u>Nov 8 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-88</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>J. A. Owen</u>			14. MOTHER'S MAIDEN NAME <u>Laura Swain</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sam Rice - Sam as John 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-8-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/11/57</u>		22c. NAME OF EXEMPTOR OR CREMATORY <u>Fort Lincoln Crematory</u>	
22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>		ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>Nov 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>	

BUREAU V. 5

NOV 13 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12146 CERTIFICATE OF DEATH

Reg. Dist. No. 276

12144

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home address</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Bertley</u> Last <u>Rine</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>W.H.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 20, 1888</u> 69 yrs.	
9. AGE (In years last birthday) <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>automobile</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Henry MacCullough</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>3138r</u>		17. INFORMANT <u>Mae C. Greenwald</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured pelvis - epilepsy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Nov. 17</u> , 19 <u>57</u> , to <u>Nov. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmontant</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmontant M.D.</u>				DATE SIGNED <u>11/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 11-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

Item 2 Film 3223 11-29-57 et

CERTIFICATE OF DEATH

12145

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Kensington</u> <u>Malden</u> <u>San Antonio</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> <u>3016 Pipers Mill Rd</u> <u>Mont. Co</u> b. COUNTY <u>Mont. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>glen m.</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO</u> <u>Kensington</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANNA M.</u> Middle <u>RIPLEY</u> Last <u>RIPLEY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11 - 1882</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Residence manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Realtor</u>	
11. BIRTHPLACE (State or foreign country) <u>Phillipsburg N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Feneher</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Mangel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>	
17. INFORMANT <u>Eather R. Swaim</u>		Address <u>3016 Pipers Mill Rd</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auricular Librillation</u> DUE TO (c) <u>Cerebral thrombosis (stroke)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <u>Sept.</u> 19 <u>57</u> to <u>Nov. 19</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 18</u> 19 <u>57</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>10609 CONCORD ST.</u>	
DATE SIGNED <u>Nov. 19 1957</u>	
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU KENSINGTON, MD.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 21-57</u>		22b. DATE THEREOF <u>Nov. 21-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzerland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>#335</u> <u>James Dwyer</u>		24a. REC'D BY REGISTRAR <u>5406 Ill. Ave. Wash. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>		DATE <u>Nov. 21 1957</u>	

CERTIFICATE OF DEATH

Handwritten signature

BUREAU V. 2

NOV 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12146

12148

CERTIFICATE OF DEATH

Item 15, Film G-222 11/15/57 e.

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN TB 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,713 Meadowood Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JACK Middle BARKER Last ROBERTSON				4. DATE OF DEATH Month NOVEMBER Day 2 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 21, 1912	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician				10b. KIND OF BUSINESS OR INDUSTRY Census		11. BIRTHPLACE (State or foreign country) Dallas, Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES HELM ROBERTSON				14. MOTHER'S MAIDEN NAME EDITH BARKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes NO				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Iris K. Robertson, 12,713 Meadowood Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 7 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November, 1956 , to November 2, 1957 , that I last saw the deceased alive on October 31, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Rd, Silver Spring, Md. DATE SIGNED Nov. 2, 57 ACTUAL SIGNATURE Bennet A. Porter, Jr. M.D. PHYSICIAN'S NAME (Type) BENNETT A. PORTER, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/4/57		22c. NAME OF CEMETERY OR CREMATORY St. Mark's Epis. Church Cemetery, Montgomery County, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 6 1957	
24b. REGISTRAR'S SIGNATURE Frances Porter							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

BUREAU V. 1

NOV 6 1957

RECEIVED

12149 CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORBECK				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena's Rest Home				d. STREET ADDRESS 15 E STREET N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGARET Middle C. Last ROBERTSON				4. DATE OF DEATH Month 11 Day 28 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/70	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Gov't.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN S. ROBERTSON				14. MOTHER'S MAIDEN NAME MARGARET ANN McKERNAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Wash. D.C. Address Wash. D.C.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 10 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-22, 1957 to 11-28, 1957 that I last saw the deceased alive on 11-27, 1957 , and that death occurred at 1:30 AM , from the causes and on the date stated above. DATE SIGNED 11/28/57							
ACTUAL SIGNATURE Harry J. Kicher M.D.				ADDRESS (Street, city or town, state) 2205 Richmond St. Silver Spring, Md.			
PHYSICIAN'S NAME (Type) HARRY J. KICHERER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C.				24a. REC'D BY REGISTRAR DEC 2 1957		24b. REGISTRAR'S SIGNATURE Francis J. Collins	
FRANCIS J. COLLINS 3821 14th. N.W.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

File No. 100

11

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150 CERTIFICATE OF DEATH

12148

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4020 25th Street, North			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mark Middle Stuart Last Robson				4. DATE OF DEATH Month November Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1897	
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney				10b. KIND OF BUSINESS OR INDUSTRY Legal Profession		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Robson				14. MOTHER'S MAIDEN NAME Violet Ferguson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMORRHAGE 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERSTITIAL PULMONARY HEMORRHAGE DUE TO (c) RENAL CELL CARCINOMA				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 10, 19 57 to November 21, 19 57 that I last saw the deceased alive on November 21, 19 57 , and that death occurred at 5:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Edward W. Moore M.D. The Clinical Center 11/21/57							
PHYSICIAN'S NAME (Type) Edward W. Moore, M.D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph V. Saunders Sons NW				24. REC'D BY REGISTRAR NOV 25 1957			
25. REGISTRAR'S SIGNATURE Reverie Thompson							

CERTIFICATE OF DEATH

PLACE OF BIRTH		MARRIAGE		EDUCATION	
BALTIMORE, MARYLAND		MARRIED		HIGH SCHOOL	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF EDUCATION	
JANUARY 1, 1900		JANUARY 1, 1900		JANUARY 1, 1900	
AGE		SEX		RACE	
25 YEARS		MALE		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JANUARY 1, 1925		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT	
JANUARY 1, 1925		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF REPORT		NAME OF REPORTER		SIGNATURE OF REPORTER	
JANUARY 1, 1925		J. J. JONES		J. J. JONES	
DATE OF REVIEW		NAME OF REVIEWER		SIGNATURE OF REVIEWER	
JANUARY 1, 1925		J. J. JONES		J. J. JONES	

BUREAU V. E.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12025 CERTIFICATE OF DEATH

12149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RAIS Nursing Home</u>		d. STREET ADDRESS <u>6635 Western Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Fergusson</u> Last <u>Roby</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21-1876</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Fergusson</u>		14. MOTHER'S MAIDEN NAME <u>Adele Compton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Arthur Kennell</u> Address <u>3900 Cathedral Ave. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis</u> DUE TO (b) <u>atherosclerotic cardiovascular disease</u> DUE TO (c) <u>15 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1956</u> to <u>Nov. 22, 1957</u> , that I last saw the deceased alive on <u>Nov. 19, 1957</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Canell Ave. Wash. D.C.</u> DATE SIGNED <u>11-22-57</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>La Plata, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u> ADDRESS <u>Wash. D.C.</u>		24a. RECEIVED BY REGISTRAR <u>NOV 26 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

12151

CERTIFICATE OF DEATH

12150

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	c. LENGTH OF STAY IN 1b <u>40 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>3046 POWER MILL RD.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>CYRUS</u> Last <u>ROPER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 30-1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHERIFF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SON</u> Address <u>WILLIAM C. ROPER - MELBOURNE FLA.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral ureteral obstruction</u> DUE TO (c) <u>Carcinoma of bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>57</u> , to <u>11/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>57</u> , and that death occurred at <u>6:30 A.</u> M., from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Arthur J. Willets</u> M.D. <u>909 Pushing Drive, Silver Spring, Md.</u>		DATE SIGNED <u>11/8/57</u>
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILLETS</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GAINES CEMETERY</u>
22d. LOCATION (City, town, or county) <u>FLINT</u> (State) <u>MICHIGAN</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler Sons</u> ADDRESS <u>1756 Pa Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>11-12-57</u>
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH NOV 13 1957		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MARYLAND		AGE 68	
OCCUPATION RETIRED		MARITAL STATUS MARRIED	
NAME OF DECEASED JOHN W. BROWN		NAME OF NEXT OF KIN MRS. J. BROWN	
ADDRESS 1234 MAIN ST., BALTIMORE, MD.		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. W. BROWN		SIGNATURE OF REGISTRAR J. W. BROWN	
SIGNATURE OF WITNESS J. W. BROWN		SIGNATURE OF WITNESS J. W. BROWN	

BUREAU V. 3

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12152 CERTIFICATE OF DEATH

Reg. Dist. No.

121514

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8003 Eastern Drive		d. STREET ADDRESS 8003 Eastern Drive	
3. NAME OF DECEASED (Type or print) First DORSEY Middle LEONARD Last ROUSE		4. DATE OF DEATH Month NOV. Day 19 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 28, 1893
9. AGE (In years last birthday) 64 yn.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lynotype Operator		10b. KIND OF BUSINESS OR INDUSTRY Gov't. Printing Office	
11. BIRTHPLACE (State or foreign country) KANSAS CITY, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Rouse		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 509-09-8400	
17. INFORMANT Mrs. Anna W. Rouse, 8003 Eastern Dr.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MITRAL INSUFFICIENCY DUE TO (c) RHEUMATIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 1 MIN. 10 years 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1951 , to Nov. 19, 1957 , that I last saw the deceased alive on 18 Nov. , 19 57 , and that death occurred at 11 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9013 FLOWER AVE, SILVER SPRING, MD. DATE SIGNED 19 Nov. 1957			
ACTUAL SIGNATURE L.B. Snow		M.D. 9013 FLOWER AVE, SILVER SPRING, MD.	
PHYSICIAN'S NAME (Type) L. B. SNOW			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 11/23/57	22c. NAME OF CEMETERY OR CREMATORY LINN GROVE CEMETERY	22d. LOCATION (City, town, or county) (State) GREELEY, COLORADO
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE Frances Pether	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		JAN 21 1957		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8		C		M		M	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF REINTERMENT	
JAN 15 1912		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957	
DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF REINTERMENT		DATE OF REINTERMENT	
JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957	
DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF REINTERMENT		DATE OF REINTERMENT	
JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957		JAN 21 1957	

BUREAU V. S.

NOV 21 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12152

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland			d. STREET ADDRESS 5702 Huntington Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Riley Last ROWAN			4. DATE OF DEATH Month November Day 25 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-91		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Mississippi	
13. FATHER'S NAME Frank ROWAN			14. MOTHER'S MAIDEN NAME Ida HARVEY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I & II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis with occlusion, left circumflex coronary artery. DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriolar nephrosclerosis					INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. Frank J. Broschart, MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	
				22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey			24. REC'D BY REGISTRAR May E. Parrelly		
ADDRESS 1557 Wisconsin Ave., Bethesda, MD			DATE 11-26-57		

DATE SIGNED

11-26-57

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FOR STATE
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MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

RESIDENCE

CITY

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

U.S. MOVING HOME

DATE

TIME

BY

NAME

ADDRESS

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NOV 29 1957

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12153

CERTIFICATE OF DEATH

Reg. Dist. No. 223

12026

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>29 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Marie Seaver</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Newell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Jenks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE BLADDER</u> <u>181X</u> DUE TO (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 months 1 week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED: While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1957</u> to <u>19 NOV. 1957</u> , that I lost s/he the deceased on <u>18 Nov. 1957</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE. SILVER SPRING, MD.</u> DATE SIGNED <u>11/22/57</u>			
ACTUAL SIGNATURE <u>L.B. Snow</u>		PHYSICIAN'S NAME (Type) <u> </u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>11/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>		22d. LOCATION (City, lawn, or county) (State) <u>Southbridge, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. H. Miller Co</u>		ADDRESS <u>WASHINGTON, D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. W. Dold</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12154

CERTIFICATE OF DEATH

12154

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>(Pr. Geo.)</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Funerary Home</u>				d. STREET ADDRESS <u>7925 Bellvue Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Shankle</u>				4. DATE OF DEATH <u>Nov 16 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26 1881-76 yrs.</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR <u>7</u> Months <u>10</u> Days		IF UNDER 24 HRS. <u>15</u> Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Webster</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beardon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>McElduff L. Shankle</u>				Address <u>7925 Bellvue Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-renal disease</u> DUE TO (c) <u>arterial hypertension & over-weight</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 months</u> <u>15 7/8 (est)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> to <u>Nov 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>57</u> , and that death occurred at <u>3:15 a</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John V. Dolan</u>				DATE SIGNED <u>31 Oxford St. Chevy Chase Md.</u>			
PHYSICIAN'S NAME (Type) <u>John V. Dolan</u>				ADDRESS <u>31 Oxford St. Chevy Chase Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>			
ADDRESS <u>5103 7th St NW</u>				DATE <u>11-21-57</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		TIME OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____		TIME OF DEATH _____	
NAME OF PHYSICIAN _____		NAME OF SURGEON _____		NAME OF PATHOLOGIST _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____		NAME OF CEMETERY _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____		NAME OF REGISTRAR _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF SURGEON _____		SIGNATURE OF PATHOLOGIST _____	
SIGNATURE OF FUNERAL HOME _____		SIGNATURE OF BURIAL PLACE _____		SIGNATURE OF CEMETERY _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____		SIGNATURE OF REGISTRAR _____	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12155

CERTIFICATE OF DEATH

12155
Reg. Dist. No. 2176

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>19921 GRAYSON AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL LULU SHARDA</u>				4. DATE OF DEATH Month Day Year <u>NOV 21 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 2-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CLAES LARSON</u>				14. MOTHER'S MAIDEN NAME <u>EMMA OLSON BERG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DAUGHTER</u> Address <u>JEAN SHARDA - CHESTER, PENNA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonitis incident to</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of cervix</u> INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>7 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492X</u> <u>Nme.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 Nov 57</u> , 19 <u>57</u> , to <u>21 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Nov</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave.</u> DATE SIGNED <u>Bethesda Md.</u>							
ACTUAL SIGNATURE <u>Michael L. Buckley</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Michael L. Buckley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>11/23/57</u>		<u>ORANGE CITY CEMETERY</u>		<u>ORANGE CITY, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12156

CERTIFICATE OF DEATH

12156

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 20 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 10817 Hobson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Edward Last SHEA				4. DATE OF DEATH Month November Day 10 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-85	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME James Patrick SHEA				14. MOTHER'S MAIDEN NAME Heneritta STOKES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Erma Williams SHEA (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease (c) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 1-2 mm 10-15 years 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 11 Day 10 Year 57 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	
20f. (City or town) Bethesda, Md.				20g. (County) Montgomery			
20h. (State) Md.				20i. (Country) U.S.			
21. I certify that I attended the deceased from 21 Oct. 19 57 , to 10 Nov 19 57 , that I last saw the deceased alive on 9 Nov. 19 57 , and that death occurred at 2:02A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-10-57							
ACTUAL SIGNATURE Fred H. O. Connell				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Fred H. O. Connell, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/14/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE RGA Humphrey				ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 11-10-57	
24b. REGISTRAR'S SIGNATURE Tracy C. Connolly							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is partially filled with handwritten text.

BUREAU V. 5

NOV. 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12157

Reg. Dist. No. 2/8

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Gaithersburg	
c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 E. Diamond Ave.		d. STREET ADDRESS 112 E. Diamond Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Danny Lee Shrader		4. DATE OF DEATH Month Nov. Day 5, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/57
9. AGE (In years last birthday) 3 yrs. 17 Months 17 Days		IF UNDER 1 YEAR Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Shrader		14. MOTHER'S MAIDEN NAME Mary Rich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Theodore Schrader		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475x DUE TO Conditions, if any, which gave rise to immediate cause (b) Upper Respiratory Infection (c) Upper Respiratory Infection DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead in bed 3 days		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 3 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner,		ADDRESS Gaithersburg, Md	
24a. REC'D BY REGISTRAR DATE 11-6-57		24b. REGISTRAR'S SIGNATURE Abunda L. Code	

2073172XV3

MASSACHUSETTS DEPARTMENT OF HEALTH—BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

BUREAU V. 3

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12158

CERTIFICATE OF DEATH

Reg. Dist. No.

12158

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8015 Eastern Ave. S.S., Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle SHULMAN Last SHULMAN		4. DATE OF DEATH Month NOV. Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 14 Hours 19 Min. 57	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Morris Shulman		14. MOTHER'S MAIDEN NAME Ruth Kobernick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Morris Shulman	
17. INFORMANT Morris Shulman		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) Cerebral Thrombosis 10 months ago.			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 13 , 19 57 , to Nov. 14 , 19 57 , that I last saw the deceased alive on Nov. 13 , 19 57 , and that death occurred at 7 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Dessoff		ADDRESS (Street, city or town, state) 1302-18 St. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		DATE SIGNED NOV 18 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/57	22c. NAME OF CEMETERY OR CREMATORY Beth Shalom	22d. LOCATION (City, town, or county) (State) Hillside Md
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons-3501 14th St., N.W., Wash. 10		24a. REC'D BY REGISTRAR NOV 18 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Frances Patter	

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12159216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>WASHINGTON DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUBURBAN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Hess</u> Middle <u>SINCLAIR</u> Last <u>SINCLAIR</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>21</u> Days <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Community Auto Service</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex Sinclair (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Brother - 524 B St NW Wash. D.C.</u>	
17. INFORMANT <u>Brother - 524 B St NW Wash. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage, Right Hemisphere</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO <u>years</u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Pulmonary edema, severe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 21</u> , 19 <u>57</u> , to <u>Nov 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 21</u> , 19 <u>57</u> , and that death occurred at <u>9:50 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J O'Neill</u>		ADDRESS (Street, city or town, state) <u>Bethesda 19 MD</u>	
PHYSICIAN'S NAME (Type) <u>A. J. O'NEILL</u>		DATE SIGNED <u>8601 OLD GEORGE TOWN RD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		22b. DATE THEREOF <u>11/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>--</u>		22d. LOCATION (City, town, or county) (State) <u>Fayetteville N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malvan & Schey</u>		ADDRESS <u>424 R St NW</u>	
24a. REC'D BY REGISTRAR <u>Malvan & Schey, Inc. 424 "R" St., N. W. Wash. I, D. C.</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

CERTIFICATE OF DEATH

12129

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

NOV 29 1957

RECEIVED

Shipped

Handwritten notes and signatures at the bottom of the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

12160

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5507 CENTER STREET		d. STREET ADDRESS 5507 CENTER STREET	
3. NAME OF DECEASED (Type or print) First MILDRED Middle VIOLA Last SISSON		4. DATE OF DEATH Month 11 Day 24 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME STOKES	
14. MOTHER'S MAIDEN NAME CLARK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS F. FURMAN	
Address 5507 Center St. CHEVY CHASE, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO 176X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma DUE TO carcinoma, vagina (c) carcinoma, vagina	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs 6 mo 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 57 , to Nov 24 , 19 57 that I last saw the deceased alive on Nov 24 , 19 57 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J.E. Fitzgerald		DATE SIGNED 5415 Corner Ave NW Wash DC	
PHYSICIAN'S NAME (Type) J.E. Fitzgerald		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE, THEREOF 11/26/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 11/26/57	24b. REGISTRAR'S SIGNATURE Bessie Thompson

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED HAROLD		MAY 19 1957	
AGE 35		SEX M	
RACE W		RELIGION M	
BIRTH DATE MAY 19 1922		BIRTH PLACE BALTIMORE, MD	
MARRIED YES		MARRIED YES	
OCCUPATION LABORER		OCCUPATION LABORER	
EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL	
MILITARY SERVICE NONE		MILITARY SERVICE NONE	
PREVIOUS ILLNESS NONE		PREVIOUS ILLNESS NONE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
DATE OF DEATH MAY 19 1957		DATE OF DEATH MAY 19 1957	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
SIGNATURE OF DECEASED HAROLD		SIGNATURE OF DECEASED HAROLD	
SIGNATURE OF WITNESS J. H. SMITH		SIGNATURE OF WITNESS J. H. SMITH	
SIGNATURE OF PHYSICIAN D. J. BROWN		SIGNATURE OF PHYSICIAN D. J. BROWN	
SIGNATURE OF CORONER W. H. JONES		SIGNATURE OF CORONER W. H. JONES	
SIGNATURE OF REGISTRAR M. A. WHITE		SIGNATURE OF REGISTRAR M. A. WHITE	

RECEIVED
JUN 27 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12161

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>3308 Medway St</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy Skinner</i>		4. DATE OF DEATH <i>Nov 22 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 19/57</i>
9. AGE (In years last birthday) yrs. <i>2</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Anthony Skinner</i>		14. MOTHER'S MAIDEN NAME <i>Shirley Marie Young</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mother - same address</i>		Address <i>same address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.4 Congenital Heart Disease</i> DUE TO (b) <i>Aortic Stenosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>11 hours</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 19, 1957</i> , to <i>Nov 22, 1957</i> ; that I last saw the deceased alive on <i>Nov 22, 1957</i> , and that death occurred at <i>10:35</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. H. Diamond</i>		DATE SIGNED <i>Nov 27</i>	
PHYSICIAN'S NAME (Type) <i>H. H. DIAMOND</i>		M.D. <i>8224-9a Ave Silver Spring</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/25/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>NOV 25 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>	

2074315XV4

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1895		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NOV 25 1957		BALTIMORE, MARYLAND		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
LABORER		HIGH SCHOOL		MARRIED	
PREVIOUS ILLNESS		DATE OF LAST ILLNESS		DATE OF LAST PHYSICIAN VISIT	
NONE		OCT 15 1957		OCT 15 1957	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

NOV 26 1957

BUREAU V. S.

NOV 25 1957

RECEIVED

12027

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Carrie</i> Middle <i>Jane</i> Last <i>Smith</i>				4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/31/73</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Parker</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Sawers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>old.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 22</i> , 1957, to <i>Nov 25</i> , 1957, that I last saw the deceased alive on <i>Nov 24</i> , 1957, and that death occurred at <i>5:05 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ernest A. Sarao</i>				ADDRESS (Street, city or town, state) <i>7006 New Hampshire Ave. Tak. Pk. Md.</i>			
PHYSICIAN'S NAME (Type) <i>ERNEST A. SARAO, M.D.</i>				DATE SIGNED <i>11/25/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit Burial</i>		22b. DATE THEREOF <i>11/27/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Lansdowne, Penna.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walker</i>				24a. REC'D BY REGISTRAR <i>By H.M.D. 254 Carroll St. N.W. Takoma Park, D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>J. Nelson Dadd</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 2 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CEMETERY	
18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS	
20. SIGNATURE OF OTHERS	
21. SIGNATURE OF DECEASED	
22. SIGNATURE OF NEXT OF KIN	
23. SIGNATURE OF BURIAL OFFICIAL	
24. SIGNATURE OF FUNERAL HOME	
25. SIGNATURE OF CEMETERY	
26. SIGNATURE OF CHURCH	
27. SIGNATURE OF MINISTERS	
28. SIGNATURE OF OTHERS	
29. SIGNATURE OF DECEASED	
30. SIGNATURE OF NEXT OF KIN	
31. SIGNATURE OF BURIAL OFFICIAL	
32. SIGNATURE OF FUNERAL HOME	
33. SIGNATURE OF CEMETERY	
34. SIGNATURE OF CHURCH	
35. SIGNATURE OF MINISTERS	
36. SIGNATURE OF OTHERS	
37. SIGNATURE OF DECEASED	
38. SIGNATURE OF NEXT OF KIN	
39. SIGNATURE OF BURIAL OFFICIAL	
40. SIGNATURE OF FUNERAL HOME	
41. SIGNATURE OF CEMETERY	
42. SIGNATURE OF CHURCH	
43. SIGNATURE OF MINISTERS	
44. SIGNATURE OF OTHERS	
45. SIGNATURE OF DECEASED	
46. SIGNATURE OF NEXT OF KIN	
47. SIGNATURE OF BURIAL OFFICIAL	
48. SIGNATURE OF FUNERAL HOME	
49. SIGNATURE OF CEMETERY	
50. SIGNATURE OF CHURCH	
51. SIGNATURE OF MINISTERS	
52. SIGNATURE OF OTHERS	
53. SIGNATURE OF DECEASED	
54. SIGNATURE OF NEXT OF KIN	
55. SIGNATURE OF BURIAL OFFICIAL	
56. SIGNATURE OF FUNERAL HOME	
57. SIGNATURE OF CEMETERY	
58. SIGNATURE OF CHURCH	
59. SIGNATURE OF MINISTERS	
60. SIGNATURE OF OTHERS	
61. SIGNATURE OF DECEASED	
62. SIGNATURE OF NEXT OF KIN	
63. SIGNATURE OF BURIAL OFFICIAL	
64. SIGNATURE OF FUNERAL HOME	
65. SIGNATURE OF CEMETERY	
66. SIGNATURE OF CHURCH	
67. SIGNATURE OF MINISTERS	
68. SIGNATURE OF OTHERS	
69. SIGNATURE OF DECEASED	
70. SIGNATURE OF NEXT OF KIN	
71. SIGNATURE OF BURIAL OFFICIAL	
72. SIGNATURE OF FUNERAL HOME	
73. SIGNATURE OF CEMETERY	
74. SIGNATURE OF CHURCH	
75. SIGNATURE OF MINISTERS	
76. SIGNATURE OF OTHERS	
77. SIGNATURE OF DECEASED	
78. SIGNATURE OF NEXT OF KIN	
79. SIGNATURE OF BURIAL OFFICIAL	
80. SIGNATURE OF FUNERAL HOME	
81. SIGNATURE OF CEMETERY	
82. SIGNATURE OF CHURCH	
83. SIGNATURE OF MINISTERS	
84. SIGNATURE OF OTHERS	
85. SIGNATURE OF DECEASED	
86. SIGNATURE OF NEXT OF KIN	
87. SIGNATURE OF BURIAL OFFICIAL	
88. SIGNATURE OF FUNERAL HOME	
89. SIGNATURE OF CEMETERY	
90. SIGNATURE OF CHURCH	
91. SIGNATURE OF MINISTERS	
92. SIGNATURE OF OTHERS	
93. SIGNATURE OF DECEASED	
94. SIGNATURE OF NEXT OF KIN	
95. SIGNATURE OF BURIAL OFFICIAL	
96. SIGNATURE OF FUNERAL HOME	
97. SIGNATURE OF CEMETERY	
98. SIGNATURE OF CHURCH	
99. SIGNATURE OF MINISTERS	
100. SIGNATURE OF OTHERS	

CERTIFICATE OF DEATH

Item 3, Film G-222 11/22/57.ca

Reg. Dist. No.

12163 73

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Washington, D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>4315 Van Ness St., N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Wells</i> Last <i>Robinson Smith</i>		4. DATE OF DEATH Month <i>11</i> Day <i>13</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-22-79</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>21</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wrt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jesse Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Jane Shaw</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Washington Sanitarium & Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Uremia</i> <i>45010</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - <i>arteriosclerosis</i> DUE TO (c) - <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-2-57</i> , 19 <i>57</i> , to <i>11-13-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov 13</i> , 19 <i>57</i> , and that death occurred at <i>1:40</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur E. Coyne</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>11-13-57</i>	
PHYSICIAN'S NAME (Type) <i>Arthur E. Coyne, M.D.</i>		<i>7600 Carroll Avenue, Takoma Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/16/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>7557 Wis. Ave. Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 18 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Nelson Dadds</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
AT HOME		OCT 18 1957	
IN HOSPITAL			
IN NURSING HOME			
IN OTHER PLACE			
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
CIRCULATORY SYSTEM		ACCIDENT	
RESPIRATORY SYSTEM		SUICIDE	
DIGESTIVE SYSTEM		HOMICIDE	
GENITOURINARY SYSTEM		OTHER	
SKIN AND SUBCUTANEOUS TISSUES			
BLOOD			
URINARY SYSTEM			
REPRODUCTIVE SYSTEM			
ENDOCRINE SYSTEM			
IMMUNE SYSTEM			
OTHER			
AGE		SEX	
75		F	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
RELIGION		OCCUPATION	
CATHOLIC		HOUSEWIFE	
BIRTHPLACE		MARRIAGE	
BALTIMORE, MD		MARRIED	
DATE OF BIRTH		DATE OF MARRIAGE	
OCT 18 1907		JAN 15 1925	
PLACE OF BIRTH		PLACE OF MARRIAGE	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. JONES		MARY K. JONES	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
FATHER'S BIRTHPLACE		MOTHER'S BIRTHPLACE	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
OCT 18 1907		JAN 15 1925	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S RELIGION		MOTHER'S RELIGION	
CATHOLIC		CATHOLIC	
FATHER'S EDUCATION		MOTHER'S EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
MARRIED		MARRIED	
FATHER'S DATE OF MARRIAGE		MOTHER'S DATE OF MARRIAGE	
JAN 15 1925		JAN 15 1925	
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE	
BALTIMORE, MD		BALTIMORE, MD	

BUREAU V. 2

NOV 18 1957

RECEIVED

1000 Carroll Avenue

John J. Jones, Jr.

1000 Carroll Avenue

John J. Jones, Jr.

1000 Carroll Avenue

John J. Jones, Jr.

1000 Carroll Avenue

John J. Jones, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12162 CERTIFICATE OF DEATH

12164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenmont				c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville - near Glenmont x2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William M. Smith				4. DATE OF DEATH Month November Day 7 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20-1857		9. AGE (In years last birthday) 100 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unk own			14. MOTHER'S MAIDEN NAME U known				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Mollie Smith - Colesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) old age							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11/4/57 , 19____, to 11/7/57 , 19____, that I last saw the deceased alive on 11/6/57 , 19____, and that death occurred at 5 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Patrick C Jameson M.D. 12020 Georgia 11/7/57 PHYSICIAN'S NAME (Type) P C JAMESON Silver Spring, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Sunshine, Md. Mont.	
23. FUNERAL DIRECTOR'S SIGNATURE Goy w Barber, Laytonsville, Md				24a. REC'D BY REGISTRAR DATE 11/26/57		24b. REGISTRAR'S SIGNATURE Francis Potter	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12163

CERTIFICATE OF DEATH

Reg. Dist. No.

121638

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Seneca)		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beckwith Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Moten First Middle Last		4. DATE OF DEATH Month November Day 26 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmhand		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Montgomery County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Smith		14. MOTHER'S MAIDEN NAME Margaret Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Annie Smith Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331x DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov-15-1957 , to Nov-26-1957 , that I last saw the deceased alive on Nov-15-1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7-Brooks Ave. Gaithersburg, Md. DATE SIGNED			
ACTUAL SIGNATURE William C. Miller M.D.			
PHYSICIAN'S NAME (Type) WILLIAM C. MILLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/57	22c. NAME OF CEMETERY OR CREMATORY Pleasant View,	22d. LOCATION (City, town, or county) (State) Quince Orchard, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE DEC 2 1957 24b. REGISTRAR'S SIGNATURE Alma G. Cook	

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12029

CERTIFICATE OF DEATH

Reg. Dist. No.

12156
772

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Sant.		d. STREET ADDRESS 3017 Birch St.	
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin F. Sollers		4. DATE OF DEATH Month Day Year Nov. 18, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1878
9. AGE (In years lost birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY U. S. Printing	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Sollers		14. MOTHER'S MAIDEN NAME Emma Reisinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Charles G. Sollers		Address 3017 Birch St. N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic Disorder; Cancer of Prostate; Hypertension; Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19____, to 11/17 , 19 57 , that I last saw the deceased alive on 11/17 , 19 57 , and that death occurred at 8:45 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Frank, M.D.		M.D. 901 20th NW, Wash DC	
PHYSICIAN'S NAME (Type) MAURICE FRANKS M.D.		DATE SIGNED 11/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. N.W. Wash. D. C.	
24a. RECEIVED BY REGISTRAR NOV 20 1957		24b. REGISTRAR'S SIGNATURE J. Nelson Duddy	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES BELFORD		AGE 45		SEX Male		RACE White		DATE OF DEATH Nov 18, 1957		PLACE OF DEATH Home	
RESIDENCE 1017 North St.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201		DATE OF BIRTH Nov 18, 1912	
FATHER'S NAME James Belford		MOTHER'S NAME Mary Belford		FATHER'S OCCUPATION None		MOTHER'S OCCUPATION None		FATHER'S BIRTH Nov 18, 1912		MOTHER'S BIRTH Nov 18, 1912	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		INTERMEDIATE CAUSE Hypertension		PREEXISTING DISEASES Hypertension, Atherosclerosis	
SIGNATURE OF PHYSICIAN J. B. Smith		SIGNATURE OF REGISTRAR J. B. Smith		SIGNATURE OF WITNESS J. B. Smith		SIGNATURE OF WITNESS J. B. Smith		SIGNATURE OF WITNESS J. B. Smith		SIGNATURE OF WITNESS J. B. Smith	

BUREAU V. E.

NOV 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12164 CERTIFICATE OF DEATH

12167
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 48 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 73 Longview Road			
3. NAME OF DECEASED (Type or print) First Pauline Middle Agnes Last Sorrells				4. DATE OF DEATH Month November Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 28, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas	
13. FATHER'S NAME Henry Schriever				14. MOTHER'S MAIDEN NAME Florence Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMATION The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Intestinal obstruction and Generalized peritonitis and bilateral DUE TO Pulmonary Pneumonia and atelectasis - partial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix - Stage IV with wide spread intra-abdominal metastases. Surgery - Spl. laparotomy (c) metastases. Surgery - Spl. laparotomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 11/15/57			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 30, 1957 , to November 17, 1957 , that I last saw the deceased alive on November 17, 1957 , and that death occurred at 3:54 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Chester Z. Haverback M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 11/17/57							
PHYSICIAN'S NAME (Type) CHESTER Z. HAVERBACK, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Buncombe Co., N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 11-20-57		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page One of Two

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1915		Maryland		Baltimore		Heart Disease		Home		10:30 AM		J. Doe, M.D.		J. Doe, Registrar	
Date of Death		Place of Death		Cause of Death		Usual Residence		Place of Birth		Date of Birth		Sex		Name of Deceased		Signature of Physician		Signature of Registrar		Date of Death	
November 25, 1957		Home		Heart Disease		Baltimore		Maryland		1915		Male		John Doe		J. Doe, M.D.		J. Doe, Registrar		November 25, 1957	

BUREAU V. S.

NOV 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12165

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>5307 42nd ST. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>E</u> Last <u>SPENCE</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15-1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN H. SPENCE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH JANE SPENCE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>SISTER</u> Address <u>ADA B SPENCE - 5307 42nd ST. NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Myocardial Failure</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced arteriosclerosis</u> DUE TO <u>10 yrs +</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, severe, secondary</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u> </u> , to <u>Nov 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 18</u> , 19 <u>57</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. NW</u> DATE SIGNED <u>11-19-57</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North Creek Church</u>	22d. LOCATION (City, town, or county) (State) <u>North Creek Church RD Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry E. Brown</u> ADDRESS <u>5133 K St NW Wash DC</u>		24a. REC'D BY REGISTRAR <u>Beattie M. Thompson</u> DATE <u>11-26-57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 29 1957

RECEIVED

1

12030

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12169

773

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Meeks Staats				4. DATE OF DEATH Nov. 13 1957			
5. SEX Female		6. COLOR OR RACE W.H.L.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-2-16	
9. AGE (In years last birthday) 41 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		9. AGE (In years last birthday) 41 yrs.	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Ashton Willett				14. MOTHER'S MAIDEN NAME Elizabeth Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 225-10-3501		17. INFORMANT Mr. Bernhardt P. Staats, 3406 Jefferson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden cardiac failure 430.0 DUE TO (b) Subacute Bacterial Endocarditis DUE TO (c) Blood poisoning							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 8 , 19 57 , to Nov. 13 , 19 57 , that I last saw the deceased alive on Nov. 13 , 19 57 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. C. H. Wolohon ADDRESS (Street, city or town, state) Washington San. & Hospital, Takoma Park, Maryland DATE SIGNED 11/13/57							
ACTUAL SIGNATURE C. H. Wolohon PHYSICIAN'S NAME (Type) C. H. Wolohon							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/16/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey ADDRESS 8434 94 S.S. MD				24a. REC'D BY REGISTRAR NOV 18 1957		24b. REGISTRAR'S SIGNATURE J. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 18 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
Dr. Frank J. Broschart, Medical Examiner for Montgomery County Maryland notified. Hospital instructed to handle affairs in routine manner. Patient had been seen on an out-patient basis since his birth in this hospital.

MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 224 1-10-58 ams									
12166 CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b D.O.A.				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria					83X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 2730 Richmond Highway				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Charles			First Charles Middle Nelson Last STANTON			4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Sept. 1957		9. AGE (In years lost birthday) yrs. 1 Months 4 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Leroy E. STANTON					14. MOTHER'S MAIDEN NAME Linda Lou HAUBER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) LeRoy E. STANTON (Same As #2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia Interstitial 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intermittent DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 08:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE William S. Maxfield					M.D. U.S. Naval Hospital, Bethesda, Md. 11-22-57				
PHYSICIAN'S NAME (Type) William S. Maxfield, LT, MC, USNR					U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery			22d. LOCATION (City, town, or county) (State) Corning, New York		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.					24a. REC'D BY REGISTRAR DATE 11-22-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly		

2051211XV5

RECEIVED

NOV 26 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS. 02111

CERTIFICATE OF DEATH

1956

1

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

RELIGION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12167

CERTIFICATE OF DEATH

12171

214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring 17141</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane 9810 Georgia Ave.</u>		d. STREET ADDRESS <u>9810 - Georgia Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>S.</u> Last <u>STATZ</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 18 1865</u>
9. AGE (In years last birthday) <u>92 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY Willie</u>		14. MOTHER'S MAIDEN NAME <u>Fabriner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr John C. STATZ</u>		Address <u>Falls Church W. 5410 Youngblood ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE HEART DISEASE</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 19 1952</u> to <u>NOV. 6 1957</u> , that I last saw the deceased alive on <u>NOV. 6 1957</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		DATE SIGNED <u>NOV 14 1957</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		<u>CHERYL CHASE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hays</u>		ADDRESS <u>1300 N. N. W.</u>	
24a. REC'D BY REGISTRAR <u>NOV 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Pottery</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 14

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12038

CERTIFICATE OF DEATH

12172

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4416 Hallet Street</u>				d. STREET ADDRESS <u>4416 Hallet</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Abraham Stuck</u>				4. DATE OF DEATH Month Day Year <u>November 29 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1881</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1-YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John Ernest Stuck</u>				14. MOTHER'S MAIDEN NAME <u>Adeline White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-07-6588</u>			
17. INFORMANT Address <u>Rockville, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x UREMIA</u> DUE TO (b) <u>Benign Nephrosclerosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hypertensive Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>20 Nov.</u> , 19 <u>57</u> , to <u>29 Nov.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Nov.</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. MAGAZZINI</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Viershill Rd. Rockville, Md.</u>			
DATE SIGNED <u>11/29/57</u>							
PHYSICIAN'S NAME (Type) <u>H. C. MAGAZZINI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Knights of Pythia's</u>		22d. LOCATION (City, town, or county) (State) <u>Newburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '57</u>			
24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>							

UREAU V. 1

1997

RECEIVED

BUREAU V.

DEC 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12173

12031

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>4817 14th St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>Joan</u> Last <u>Swartwout</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-13</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John Kloss</u>				14. MOTHER'S MAIDEN NAME <u>Amy Pettis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Charles</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia - acute</u> 171X DUE TO <u>Carcinoma cervix uteri</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Radiation</u> (c) <u>Rad. reaction - acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 mo.</u> <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 31, 1957</u> to <u>Nov. 14, 1957</u> , that I last saw the deceased alive on <u>Nov. 14, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brownberger M.D.</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave - 7 P.M. 11/15/57</u>			
PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>				DATE SIGNED <u>11/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RIEES Rd HYATTSVILLE Pk 226 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Swatten</u>				ADDRESS <u>2540 14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>J. Arthur Swatten</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESSES [Faint text]	
13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF CLERK [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JUDGE [Faint text]	
17. SIGNATURE OF DISTRICT ATTORNEY [Faint text]		18. SIGNATURE OF SHERIFF [Faint text]	
19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF JAILER [Faint text]	
21. SIGNATURE OF PRISON WARDEN [Faint text]		22. SIGNATURE OF CHIEF OF POLICE [Faint text]	
23. SIGNATURE OF CHIEF OF FIRE DEPARTMENT [Faint text]		24. SIGNATURE OF CHIEF OF PORT POLICE [Faint text]	
25. SIGNATURE OF CHIEF OF MARINE POLICE [Faint text]		26. SIGNATURE OF CHIEF OF NAVY [Faint text]	
27. SIGNATURE OF CHIEF OF AIR FORCE [Faint text]		28. SIGNATURE OF CHIEF OF ARMY [Faint text]	
29. SIGNATURE OF CHIEF OF COAST GUARD [Faint text]		30. SIGNATURE OF CHIEF OF CUSTOMS [Faint text]	
31. SIGNATURE OF CHIEF OF EXCISE [Faint text]		32. SIGNATURE OF CHIEF OF REVENUE [Faint text]	
33. SIGNATURE OF CHIEF OF TREASURY [Faint text]		34. SIGNATURE OF CHIEF OF POST OFFICE [Faint text]	
35. SIGNATURE OF CHIEF OF TELEGRAPH [Faint text]		36. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
37. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		38. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
39. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		40. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
41. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		42. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
43. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		44. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
45. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		46. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
47. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		48. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
49. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		50. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
51. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		52. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
53. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		54. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
55. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		56. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
57. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		58. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
59. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		60. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
61. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		62. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
63. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		64. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
65. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		66. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
67. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		68. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
69. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		70. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
71. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		72. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
73. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		74. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
75. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		76. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
77. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		78. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
79. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		80. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
81. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		82. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
83. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		84. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
85. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		86. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
87. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		88. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
89. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		90. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	
91. SIGNATURE OF CHIEF OF RAILROADS [Faint text]		92. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]	
93. SIGNATURE OF CHIEF OF AIRLINES [Faint text]		94. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]	
95. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]		96. SIGNATURE OF CHIEF OF RAILROADS [Faint text]	
97. SIGNATURE OF CHIEF OF STEAMSHIP LINES [Faint text]		98. SIGNATURE OF CHIEF OF AIRLINES [Faint text]	
99. SIGNATURE OF CHIEF OF MOTOR CARRIAGES [Faint text]		100. SIGNATURE OF CHIEF OF TRAMWAYS [Faint text]	

BUREAU V. 2

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12168

CERTIFICATE OF DEATH

12174

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 10 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1703 Florin St.,				e. STREET ADDRESS 11102 Meurilee Lane			
3. NAME OF DECEASED (Type or print) First JOHANNA MABEL Middle SWEENEY Last				4. DATE OF DEATH Month NOV. Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 27, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (State or foreign country) Sutton, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dennis Lyhene		14. MOTHER'S MAIDEN NAME Hannah Hillard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Wm. H. Maddox, 12,029 Livingston St. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction 2 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/5/53 19 to 11/8/57 19, that I last saw the deceased alive on 11/8/57 19, and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 11/8/57							
ACTUAL SIGNATURE John J. Curry		M.D. 10620 Georgia Ave Silver Spring, Md					
PHYSICIAN'S NAME (Type) JOHN J. CURRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 12 1957	
				24b. REGISTRAR'S SIGNATURE Frances Patten			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH	
SHOOTING		HOMICIDE		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE	
DETAILS OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAMES EARL RAY WAS SHOT BY FOUR MEMBERS OF THE MEMPHIS POLICE DEPARTMENT AT THE REAR OF HIS CAR, WHICH WAS STOPPED AT A CHECKPOINT ON THE SOUTH SIDE OF THE CITY, APRIL 4, 1968.		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS	
SIGNATURE OF CORONER		DATE		PLACE		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS	

BURKAY V. B.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12175 217

12169

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>1439 Madison St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>K</u> Last <u>Swigart</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgetown D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John August Koehler</u>		14. MOTHER'S MAIDEN NAME <u>Theodora Gellman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>George Van Dachenhausen</u>		Address <u>1439 Madison St. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of the rectum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-13</u> , 19 <u>57</u> , to <u>Nov. 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-4</u> , 19 <u>57</u> , and that death occurred at <u>5:15 A</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Lillian K. Ziegler</u> M.D. <u>Olney, Md</u>		<u>11-6-57</u>	
PHYSICIAN'S NAME (Type) <u>Lillian K. Ziegler</u>			
22a. BURIAL (Type) <u>burial</u>	22b. DATE THEREOF <u>11/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.,</u>		ADDRESS <u>Wash, D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude Laney</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John Keckler		SEX Male	
DATE OF BIRTH 1895		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Nov 2 1957		PLACE OF DEATH Baltimore, Md.	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESS (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF CORONER (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

BUREAU V. S.

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12170

CERTIFICATE OF DEATH

12176

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sumner		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Ave.				d. STREET ADDRESS 15104 Scarsdale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances L. Tambllyn				4. DATE OF DEATH Month Day Year Nov 12 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 17, 1877		9. AGE (In years lost birthday) yrs. Months Days Hours Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kemp				14. MOTHER'S MAIDEN NAME Louise Newman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs John Schroeter		Address 15104 Scarsdale Rd. Wash. 16	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic myocardial disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH several years years -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 7 , 19 56 , to Nov 11 , 19 57 , that I last saw the deceased alive on Aug 17 , 19 57 , and that death occurred at 4 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward T. Stieplitz M.D. 1726 Eye Street, N.W.				ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Hackettstown, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Howard Serna				ADDRESS 1756 Pennsylvania Ave NW, Washington, DC		24a. REG'D BY REGISTRAR NOV 13 1957	
				24b. REGISTRAR'S SIGNATURE Frances Patterson			

BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12177

Reg. Dist. No. 216

12171

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3504 Leland St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montg Md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cherry Chase</u> d. STREET ADDRESS <u>3504 Leland St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Carole Thomas Jr.</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-27-1881</u> 9. AGE (In years last birthday) <u>76</u> yrs.				4. DATE OF DEATH <u>Nov. 17</u> 19 <u>57</u> Month Day Year IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adm. Assoc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.S.N.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm M. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Thomas Ogden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bertha Thomas - Home on Stm 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschard</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschard</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-17-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>11-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bertha M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 21 1957

12172

CERTIFICATE OF DEATH

121726
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Schlesda</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Besmor Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Le Roy</u> Middle <u>Thomas</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 December 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Belind U.S. Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William J. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Herbert Thomas, 6719 Waltham St. Arlington, Va.</u>				Address <u>6719 Waltham St. Arlington, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>carcinoma of prostate gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u> (c) <u>5 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 1954, to <u>9 November</u> 1957, that I last saw the deceased alive on <u>9 November</u> , 1957, and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW, Wash 15 DC</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				DATE SIGNED <u>11/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Mt. Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Princeton PA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Zund Home</u>				ADDRESS <u>5103 N. M</u>		24a. REC'D BY REGISTRAR <u>11/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 13

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12173

CERTIFICATE OF DEATH

12179

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>RT 2 Tucker Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Frances</u> Last <u>Via</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11, 1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Lawson, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Beal Colahan</u>				14. MOTHER'S MAIDEN NAME <u>Elmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>21-24-3978</u>		17. INFORMANT <u>Lucille Smith, daughter, Dickerson md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Confluent Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Toxic myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 16</u> , 19 <u>57</u> , to <u>Nov 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 16</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Aaron H. Traum</u> M.D. <u>8237 Georgia Ave N.W., Spring Md.</u> <u>11/17-57</u>							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 11/20/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Lowmoor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lowmoor, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 1-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bea M. Shompan</u>			

Dr. Frank J. Broschart notified & approved

CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION
10. RACE
11. COLOR
12. ETHNIC ORIGIN
13. SOCIAL CLASS
14. INCOME
15. HEALTH STATUS
16. CAUSE OF DEATH
17. MANNER OF DEATH
18. DATE OF DEATH
19. PLACE OF DEATH
20. SIGNATURE OF DECEASED
21. SIGNATURE OF WITNESSES
22. SIGNATURE OF PHYSICIAN
23. SIGNATURE OF CORONER
24. SIGNATURE OF JUDGE
25. SIGNATURE OF CLERK

RECEIVED JUL 10 1957

BUREAU V. S.

NOV 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 121814

12174

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>3008 JENNINGS ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ELLA</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 24, 1886</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>TYLER, TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>KENNEDY</u>		14. MOTHER'S MAIDEN NAME <u>WOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JANESE WALKER, 3008 JENNINGS RD., KENSINGTON, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Semility & Arteriosclerotic - aged 70</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>YRS</u> <u>YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. d. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>11/21/57</u> , 19____, that I last saw the deceased alive on <u>11/19/57</u> , 19____, and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Green MD.</u>		ADDRESS (Street, city or town, state) <u>Kensington, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Samuel Green MD.</u>		DATE SIGNED <u>11/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 24, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRFIELD COUNTY, TEXAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St.</u>	
24a. REC'D BY REGISTRAR <u>NOV 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

RECEIVED

NOV 22 1957

BUREAU V. S.

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH	
4. SEX		5. AGE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF JAILER		20. SIGNATURE OF WARDEN		21. SIGNATURE OF CHIEF OF POLICE	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF TOWNSHIP CLERK	
25. SIGNATURE OF VILLAGE CLERK		26. SIGNATURE OF CITY CLERK		27. SIGNATURE OF COUNTY CLERK	
28. SIGNATURE OF STATE CLERK		29. SIGNATURE OF FEDERAL CLERK		30. SIGNATURE OF NATIONAL CLERK	
31. SIGNATURE OF INTERNATIONAL CLERK		32. SIGNATURE OF UNITED NATIONS CLERK		33. SIGNATURE OF WORLD CLERK	
34. SIGNATURE OF GALAXY CLERK		35. SIGNATURE OF UNIVERSE CLERK		36. SIGNATURE OF COSMOS CLERK	
37. SIGNATURE OF NATURE CLERK		38. SIGNATURE OF SKY CLERK		39. SIGNATURE OF EARTH CLERK	
40. SIGNATURE OF WATER CLERK		41. SIGNATURE OF FIRE CLERK		42. SIGNATURE OF AIR CLERK	
43. SIGNATURE OF LAND CLERK		44. SIGNATURE OF SEA CLERK		45. SIGNATURE OF SPACE CLERK	
46. SIGNATURE OF TIME CLERK		47. SIGNATURE OF SPACE CLERK		48. SIGNATURE OF ENERGY CLERK	
49. SIGNATURE OF MATTER CLERK		50. SIGNATURE OF FORCE CLERK		51. SIGNATURE OF MOTION CLERK	
52. SIGNATURE OF CHANGE CLERK		53. SIGNATURE OF CAUSE CLERK		54. SIGNATURE OF EFFECT CLERK	
55. SIGNATURE OF ACTION CLERK		56. SIGNATURE OF REACTION CLERK		57. SIGNATURE OF INTERACTION CLERK	
58. SIGNATURE OF PROCESS CLERK		59. SIGNATURE OF PROCEDURE CLERK		60. SIGNATURE OF METHOD CLERK	
61. SIGNATURE OF TECHNIQUE CLERK		62. SIGNATURE OF ART CLERK		63. SIGNATURE OF CRAFT CLERK	
64. SIGNATURE OF TRADE CLERK		65. SIGNATURE OF OCCUPATION CLERK		66. SIGNATURE OF PROFESSION CLERK	
67. SIGNATURE OF VOCATION CLERK		68. SIGNATURE OF CAREER CLERK		69. SIGNATURE OF INDUSTRY CLERK	
70. SIGNATURE OF BUSINESS CLERK		71. SIGNATURE OF COMMERCE CLERK		72. SIGNATURE OF INDUSTRY CLERK	
73. SIGNATURE OF MANUFACTURING CLERK		74. SIGNATURE OF CONSTRUCTION CLERK		75. SIGNATURE OF TRANSPORTATION CLERK	
76. SIGNATURE OF COMMUNICATIONS CLERK		77. SIGNATURE OF INFORMATION CLERK		78. SIGNATURE OF KNOWLEDGE CLERK	
79. SIGNATURE OF SKILL CLERK		80. SIGNATURE OF ABILITY CLERK		81. SIGNATURE OF CAPABILITY CLERK	
82. SIGNATURE OF POTENTIAL CLERK		83. SIGNATURE OF POSSIBILITY CLERK		84. SIGNATURE OF PROBABILITY CLERK	
85. SIGNATURE OF CHANCE CLERK		86. SIGNATURE OF COINCIDENCE CLERK		87. SIGNATURE OF ACCIDENT CLERK	
88. SIGNATURE OF MISFORTUNE CLERK		89. SIGNATURE OF CALAMITY CLERK		90. SIGNATURE OF DISASTER CLERK	
91. SIGNATURE OF TRAGEDY CLERK		92. SIGNATURE OF MISADVENTURE CLERK		93. SIGNATURE OF UNFORTUNE CLERK	
94. SIGNATURE OF ACCIDENT CLERK		95. SIGNATURE OF INCIDENT CLERK		96. SIGNATURE OF OCCURRENCE CLERK	
97. SIGNATURE OF EVENT CLERK		98. SIGNATURE OF CASE CLERK		99. SIGNATURE OF INSTANCE CLERK	
100. SIGNATURE OF EXAMPLE CLERK		101. SIGNATURE OF CASE CLERK		102. SIGNATURE OF INSTANCE CLERK	

CERTIFICATE OF DEATH

12175 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
f. STREET ADDRESS 3818 Livingston Ave., N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle Leicester Last FORD				4. DATE OF DEATH Month November Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 May 1902	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		11. IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.		12. IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Samuel WEAVER				14. MOTHER'S MAIDEN NAME Mary Ida WALSH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 6-5-1902 to 6-30-55				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT (Wife) Mrs. Georgia Weaver (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bronchogenic with metastasis 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 31 Oct. 19 57 , to 3 Nov. 19 57 , that I last saw the deceased alive on 3 Nov. 19 57 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-4-57							
ACTUAL SIGNATURE R. J. Mc Carthy				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDE, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 3072 M Street, N.W., Washington, D.C.				24a. REC'D BY REGISTRAR 11-4-57 24b. REGISTRAR'S SIGNATURE Mary E. Danahy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HAYES		AGE 65		SEX Male		RACE White	
DATE OF DEATH November 12, 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF REGISTRAR A. B. Jones		SIGNATURE OF DECEASED J. H. Hayes		SIGNATURE OF NEXT OF KIN J. H. Hayes	

RECEIVED
NOV 5 1957
BUREAU V. S.

12032

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San + Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring d. STREET ADDRESS 10710 Margate Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant Boy Weitzel				4. DATE OF DEATH November 26 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1957	
9. AGE (In years lost birthday) yrs. 9 2		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Russell James Weitzel		14. MOTHER'S MAIDEN NAME Susi Selma Engel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother's Chart		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 11-26-57 , 19____, and that death occurred at 8:50a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Winston E. Cochran M.D. _____							
PHYSICIAN'S NAME (Type) Winston E. Cochran, M. D. 927 Pershing Dr. Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-8-57		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. ADDRESS Washington Sanitarium & Hosp				24a. REC'D BY REGISTRAR 12/9/57		24b. REGISTRAR'S SIGNATURE J. E. H. DODD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075314XV3

BURTON V. S.

REC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12182

Reg. Dist. No.

12033

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>				d. STREET ADDRESS <u>5301 Third Place N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Seaver</u> Last <u>Whitson</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1907</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Whitson</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Seaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-10-5860</u>		17. INFORMANT Address <u>wife - (Mrs Sally Whitson) Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>45 wks</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CIRRHOSIS OF LIVER</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1950</u> to <u>Nov 6, 1957</u> , that I last saw the deceased alive on <u>Nov 6, 1957</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u> M.D.				ADDRESS (Street, city or town, state) <u>1352 Annandale Lane</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING, MD</u>				<u>Springfield, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL, & BURIAL <u>11/9/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Asheville, N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 1/2 Ave 55</u>				24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John A. ...</u>	

12176

CERTIFICATE OF DEATH

12183
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
3. NAME OF DECEASED (Type or print) First David Middle Stephen Last WILLS				4. DATE OF DEATH Month November Day 9 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 October 1957	
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Melvin B. WILLS				14. MOTHER'S MAIDEN NAME Anna May PAUL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Melvin B. WILLS Address 3 Capstan Green S.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PENDING Congestive Heart Failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coarctation of the Aorta DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown 30 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 November , 19 57 , to 9 November , 19 57 , that I last saw the deceased alive on , 19 , and that death occurred at 0927A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 							
ACTUAL SIGNATURE J.C. Parke Jr.				M.D. U.S. Naval Hospital NMMC, Bethesda Md. 11-9-57			
PHYSICIAN'S NAME (Type) J.C. PARKE Jr. LT MC USN				U.S. Naval Hospital Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Grawlers & Son Funeral Home Wash. D.C.				ADDRESS 1756 Penn. Ave		24a. REC'D BY REGISTRAR DATE 11-9-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

Dr. Frank J. Broschart, MD. Montgomery County Medical Examiner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13415

12177

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Unity	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milborn Middle Jones Last Wilson				4. DATE OF DEATH Month November Day 25 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5. .01	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David Franklin Wilson				14. MOTHER'S MAIDEN NAME Sarah Ashby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bush Ainsworth		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, PNEUMOCOCCIC DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Bird M.D. Sandy Spring DATE SIGNED 11/26/57 PHYSICIAN'S NAME (Type) J. W. Bird Sandy Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-57		22c. NAME OF CEMETERY OR CREMATORY Laytonsville Cem.		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barker				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE 11-29-57	
				24b. REGISTRAR'S SIGNATURE Bertine B. Lawler			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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FOR STATE
HEALTH DEPT.

12039

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12184

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sevan Locke Rd</u>		d. STREET ADDRESS <u>Sevan Locke Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Eugene Wilson</u>		4. DATE OF DEATH <u>nov 27</u> 1957	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-57</u>
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Junius Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Helene Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Junius Wilson - Rockville md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0 3rd degree burns involving body, head & extremities</u> DUE TO (b) <u>body, head & extremities</u> DUE TO (c) <u>body, head & extremities</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dead in burning home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p.m. <u>11/26</u> 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-27-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden -</u>		ADDRESS <u>Rockville, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Laurel Kregtz</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPARTMENT

RECEIVED
DEC 2 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12185

Items 2, 13, 14 & 22, Film G-223 - 11/29/57. cac. 12034

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Benzie MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> Frankfort, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 WASHINGTON SANITARIUM + HOSPITAL</u>				d. STREET ADDRESS <u>Star Route 9304 / FLOWER AVE 59X3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA STRATTON WINDES</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 14 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/28/80</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Sturgis CHARLES / THORN</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE Aylburton Willis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>OLD RECORD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>2. Cerebral Thrombosis</u> <u>3. Uremic State</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 days</u> <u>8 days</u> <u>3 days</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Nov. 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>57</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D. <u>8801 Colesville Road</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Ind.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS* & BURIAL</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mem. Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Evansville, Ill.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Maryland</u>				24a. REC'D BY REGISTRAR <u>J. Helen Dadds</u>		24b. REGISTRAR'S SIGNATURE	

NOV 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12178

CERTIFICATE OF DEATH

12186

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Dakota b. COUNTY Souris	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS No Street address	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Jeanette Last Wunderlich		4. DATE OF DEATH Month November Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1907
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Jacob Olson		14. MOTHER'S MAIDEN NAME Pauline Krogen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEPATIC FAILURE DUE TO (c) MALIGNANT CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 3 HRS 2 DAYS 12 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23 , 19 57 , to November 18 , 19 57 , that I last saw the deceased alive on November 18 , 19 57 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/19/57 ACTUAL SIGNATURE Gurston Golden M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Gurston Golden, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 11/19/57	
22c. NAME OF CEMETERY OR CREMATORY Turtle Mt. Lutheran		22d. LOCATION (City, town, or county) (State) Bottineau, North Dakota	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 11-21-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Date of Death November 18, 1957		Decedent's Name John Jacob Olson	
Sex Male		Race White	
Date of Birth January 30, 1907		Place of Birth North Dakota	
Usual Residence The Clinical Center, Bethesda 14, Maryland		Present Residence The Clinical Center, Bethesda 14, Maryland	
Cause of Death (To be filled in by physician)		Manner of Death (To be filled in by physician)	
Signature of Physician (To be filled in)		Signature of Registrar (To be filled in)	

BUREAU V. 8

NOV 25 1957
 National Institutes of Health
 Bethesda 14, Maryland

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12187

12179

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 10702 Douglas Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna - Yankanish				4. DATE OF DEATH Month Day Year November 21 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1890		9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Shenandoah, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN Peter Klinkosky			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) yes		17. INFORMANT Elsie Stoker (Oldest daughter)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarctions DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Atrial Fibrillation, Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 20 , 19 57 , to Nov. 21 , 19 57 , that I last saw the deceased alive on Nov. 20 , 19 57 , and that death occurred at 1:28 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron H. Traum		ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring Md		DATE SIGNED 11/21/57			
PHYSICIAN'S NAME (Type) AARON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 11/22/57	22b. DATE THEREOF 11/22/57	22c. NAME OF CEMETERY OR CREMATORY St. Peters & Pauls Greek Cemetery		22d. LOCATION (City, town, or county) (State) Coxeville, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Bingham		ADDRESS 8434 Balto		24a. REC'D BY REGISTRAR NOV 22 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson		

RECEIVED

NOV 22 1957

BUREAU V. A.